



The Employee Painters' Trust Health and Welfare Plan

Actives Summary Plan Description

January 2007



PAPERMILL PRINTING

**TRUST FUND
CONTACT INFORMATION**

TRUST OFFICE

Zenith Administrators, Inc.

104 S. Freya Suite 220
Spokane, WA 99202

Submit all claims to:

PO Box 2523
Spokane, WA 99220

Submit all correspondence and payments to:

104 S. Freya Suite 220
Spokane, WA 99202

The Employee Painters' Trust Health & Welfare Plan Claims Customer Service

Telephone.....(509) 534-0265
Toll-Free.....(800) 566-4455
Fax.....(509) 534-5910

The Employee Painters' Trust Health & Welfare Plan Eligibility Customer Service

Telephone.....(509) 534-5625
Toll-Free.....(800) 522-2403

Patient Assistance Program: Hospital Pre-Certification; Home Health Care, Hospice (CareAllies)

Telephone.....(800) 932-7766

WEBSITE

www.zenithadmin.com

This website contains:

- Helpful information about your Plan
- Notices about Plan changes
- Printable versions of claims forms, change of address forms and enrollment forms
- Links to Preferred Providers
- Summary Annual Report
- Claims History
- Eligibility

Please contact the Trust Office Claims Customer Service if you need a password.

Medco by Mail – Mail Order Pharmacy

Telephone.....(800) 711-0917

First Choice Health Network (FCHN)

To find a Preferred Provider near you.....(800) 231-6935
Website..... www.fchn.com

Managed Healthcare Northwest (MHN)

For Preferred Providers in SW Washington and Oregon.....(503) 413-5800
Website..... www.mhninc.com

Sierra Healthcare Options (SHO)

For Preferred Providers in Nevada.....(800) 573-1124

YOUR GROUP INSURANCE BENEFITS

THE EMPLOYEE PAINTERS' TRUST HEALTH AND WELFARE PLAN

Actives

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.
Forward your completed claim form to:

The Employee Painters' Trust
c/o Zenith Administrators, Inc.
P.O. Box 2523
Spokane, Washington 99220
Phone: 1-509-534-0265 or 1-800-566-4455
Fax: 1-509-534-5910

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how
your claim was paid, contact:

The Employee Painters' Trust
c/o Zenith Administrators, Inc.
104 S. Freya, Suite 220
Spokane, Washington 99202
Phone: 1-509-534-0265 or 1-800-566-4455
Fax: 1-509-534-5910

A Plan Document required by law is available upon request from the Plan Administrator at the Painters' Trust Administration Office. This booklet is a Summary Plan Description and is not the contract. In the event of a conflict the Plan Document will prevail.

When you utilize a Preferred Provider Hospital or Physician, the costs to the Trust are reduced. This also reduces your out-of-pocket costs. The Trust strongly urges you to utilize Preferred Provider services whenever possible. A directory of Preferred Providers may be obtained from the Union Office, Plan Administrator, First Choice at www.fchn.com 800-231-6935, Managed Healthcare NW at www.mhninc.com 503-413-5800 or Sierra Healthcare at 800-573-1124. Members in Anchorage have two Preferred Provider Hospitals to use. If these hospitals are not utilized, benefits are reduced. Please refer to the schedule.

Utilization Review (hospital pre-certification) and Case Management for inpatient hospital services provide support so the patient can receive necessary, appropriate care while avoiding unnecessary expenses. To benefit from these programs, pre-certification from CareAllies must be received before you receive medical and/or surgical services. Call CareAllies at (800) 932-7766.

To All Eligible Employees:

Please note that there is a separate booklet for Retirees. Please contact the Trust Office if you need a Retiree Booklet.

The Board of Trustees is pleased to present you with this new Summary Plan Description describing the medical, disability and accidental death and dismemberment benefits available to you and your family from the Painters' Trust.

Please read this booklet carefully so you understand your benefits. Only the Trust Office represents the Board of Trustees in administering the Plan and providing information relating to the amount of benefits, eligibility and other Plan provisions. No participating employer, employer association, labor organization or any individual employed thereby, has any authority in this regard.

If you have any questions about your benefits, please contact the Trust Office for assistance.

Sincerely,

Board of Trustees

Mike Ball
Tim Carrier
John Smirk
Steve Bloom

Tim Bendokas
Nancy Gudmundson
Mike Guza
Gary Liles
Bob Puzas

“NOTICE - Trustees Discretion Retained. The Board of Trustees reserves the maximum legal discretionary authority to construe, interpret and apply the terms, rules and provisions of the Benefit Plan covered in this Descriptive Booklet. The Trustees retain full discretionary authority to make determinations on matters relating to eligibility for benefits, on matters relating to what services, supplies, care, drug therapy and treatments are Experimental, and on matters which pertain to Participant's rights. The decisions of the claims adjusters, Administrator, and Board of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provision of the Benefit Plan, or application of such to any claim for benefits, shall receive the maximum deference provided by law and will be final and binding on all interested parties.”

“Amendment and Termination of Benefit Plan. The Board of Trustees expects to maintain this Benefit Plan indefinitely, however, the Trustees may, in their sole discretion, at any time, amend, suspend or terminate the Benefit Plan in whole or in part. This includes amending the benefits covered by the Benefit Plan and/or the governing Trust Agreement and Policies of Administration. If the Plan is terminated, the rights of the Participants are limited to benefits incurred before termination. All amendments to this Plan shall become effective as of a date established by the Board of Trustees.”

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully under the General Exclusions and Limitations in this booklet. This includes, but is not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Definitions section of this document.

The Plan is a plan that contains Preferred Provider Organizations.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Preferred Providers. These Preferred Providers have agreed to charge reduced fees to persons covered under the Plan.

Therefore, when an Insured Person uses a Preferred Provider, that Insured Person will owe a lesser amount than when a Non-participating Provider is used. It is the Insured Person's choice as to which Provider to use.

Additional information about this option, as well as a list of Preferred Providers will be given to covered Employees and updated as needed.

DEDUCTIBLES

Deductibles are dollar amounts that the Insured Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Insured Person. Typically, there is one deductible amount per person and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required unless otherwise specified.

Any amount applied to the deductible in the last three months of a Calendar Year will be carried over and applied to the deductible amount for the next Calendar Year.

SERVICES	BENEFITS	MATERIAL HANDLERS	
MAXIMUM BENEFIT AMOUNT	\$1,000,000	\$1,000,000	
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	\$300	\$450	
Per Family Unit	\$900	\$1350	
MAXIMUM OUT-OF-POCKET, PER CALENDAR YEAR	\$1300 Per Person	\$3450	
The Plan will pay the designated percentage of covered charges until the above listed amount of out-of-pocket payments is reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of that Calendar Year unless stated otherwise.			
Hospital Services			
		PPO PROVIDERS	NON-PPO PROVIDERS
Room and Board	80% of the semiprivate room rate	80%	60%
Intensive Care Unit	80% of the Hospital's ICU charge	80%	60%
Emergency Room	80% after \$100 co-pay	80% after \$100 co-pay	60% after \$100 co-pay
Outpatient Services	80%	80%	60%
Skilled Nursing Facility Refer to page 35 for limitations	80%	60%	
Physicians Services (NOTE: ALL PHYSICIANS' SERVICES ARE SUBJECT TO THE USUAL AND CUSTOMARY CLAUSE EXCEPT WHEN PERFORMED BY PPO PROVIDERS)			
Office Visits	80%	80%	60%
Inpatient Visits	80%	80%	60%
Surgery	80%	80%	60%
Home Health Care (must meet plan requirements, refer to page 35)	100% not to exceed 130 visits in any calendar year		
Neurological and Initial Psychological Tests and Evaluations	80%	80%	60%
Hospice Care (must meet Plan requirements. Refer to page 36)	100% not to exceed 180 days of inpatient and out-patient services in any covered person's lifetime		
Ambulance (to the nearest hospital equipped to furnish the services)	80% Commercial airline transportation may be covered if medically necessary.	80%	60%
Physical/Occupational Therapy Limited to 60 visits per year (must be prescribed by physician)	80%	80%	60%
Neurodevelopmental Disorders \$2000 Lifetime Maximum (limited to Dependents age 6 and under)	80%	80%	60%

SERVICES	BENEFITS	MATERIAL HANDLERS	
		PPO PROVIDERS	NON-PPO PROVIDERS
Speech Therapy Limited to 30 visits per year (must be for restoration of lost speech due to diagnosed illness or Injury)	80%	80%	60%
Durable Medical and Respiratory Equipment	80%	80%	60%
Prosthetics	80%	80%	60%
Orthotics Not Covered except for diabetics	80%	80%	60%
Spinal Manipulation/Chiropractic Services % up to \$20 maximum per visit. 24 visits per calendar year	80%	80%	60%
Temporomandibular Joint Disorder (TMJ) \$5,000 Lifetime Maximum Regular Plan benefits for jaw surgery if treatment started within 12 months from date of injury.	80%	80%	60%
Note: The above charges for TMJ will not be counted in accumulating covered charges toward the 100% payment percentage of other charges, nor will these charges be subject to the 100% payment.			
Mental Disorders			
Inpatient 10 Inpatient Hospital days Calendar Year maximum	80%	80%	60%
Outpatient Limited to 20 visits per Calendar Year maximum	80%	80%	60%
Substance Abuse/Chemical Dependency Inpatient and Outpatient	80% to a maximum of the greater of \$13,000 or \$13,000 plus any adjustment based on the Consumer Price Index during a 24 month period which increases \$500 each year. (Detoxification is not subject to \$13,000 maximum)		
Pregnancy (Employee and Spouse only)	80%	80%	60%
Newborn Care (limited to bassinet, nursery, and Physician charges while baby and mother are inpatient)	80%	80%	60%

SERVICES	BENEFITS	MATERIAL HANDLERS	
Preventive Care Benefits			
Routine Physican Exams (age 24 months or older) Includes physician's routine office visits, lab and x-ray services, routine cancer screening, smoking cessation treatment (office visit and prescribed medications) % (not subject to deductible) \$300 annual maximum	100%	100%	
(Dependent Children under the age of 24 months) Includes physician's preventative health care services, inoculations as recommended by the ACIP, oral polio vaccine and tests for tuberculosis. (not subject to deductible)	100% to \$2500 maximum	100% to \$2500 maximum	
		PPO PROVIDER	NON-PPO PROVIDERS
Preventative Care Female Employee or Spouse One routine pap smear including physician's charges. Routine mammograms (not subject to deductible)	80%	80%	60%
Hearing Aids \$350 per ear each 36 months (does not include battery or other ancillary equipment replacement)	80%	80%	60%
Acupuncture, Massage Therapy and Naturopathic Care Up to 24 visits per year for each service	80%	80%	60%
PRESCRIPTION DRUGS You have three choices as to how you would like to obtain your prescription drugs. Co-payments for mail order and retail plans are:	Reimbursement Plan; OR Medco by Mail, or; 20% for Generic Drugs ExpressScripts 25% for Brand Drugs when Generic is not available 50% for Brand Drugs when Generic is available \$5000 maximum out of pocket		

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DEFINITIONS

When used in the booklet:

Acupuncture means the practice of insertion of needles into specific exterior body locations to:

- (a) relieve pain;
- (b) induce surgical anesthesia; or
- (c) for therapeutic purposes.

Administrator or Plan Administrator means Zenith Administrators, Inc.

Bargaining Unit Employee means a person:

- (a) in good standing in the International Brotherhood of Painters, Decorators and Paperhangers of America, residing within commuting distance and available for work within the jurisdictional area of a Union local accepted by the Trust as a participating Union local; and
- (b) with respect to a Contributing Employer, under the terms of a collective bargaining agreement, is making contributions to the Trust for each hour worked by such employee for the purchase of health and welfare benefits, exclusive of any retirement benefits.

Body Organ means any of the following:

- (a) kidney;
- (b) heart;
- (c) heart/lung;
- (d) liver;
- (e) pancreas (when the condition is not treatable by use of insulin therapy);
- (f) bone marrow; and
- (g) cornea.

Brand Name Drug means a covered proprietary Drug approved by the Federal Food and Drug Administration.

Calendar Year is January 1st to December 31st of the same year.

Certificate means the Certificate of Insurance form and all other documents that describe insurance coverage under the Plan and are made a part of the Plan.

Contributing Employer means any person or entity who, pursuant to a collective bargaining agreement, is making payments to the Trust for the purchase of health and welfare benefits for employees in job classifications covered by such bargaining agreement.

Copayment means an amount which the Insured Person must pay before benefits are payable, and which is incurred on the date the Covered Drug or service is received. Copayments may not be used to satisfy any deductible or the major medical stop-loss limit.

Cosmetic Surgery means any surgical procedure performed primarily:

- (a) to improve physical appearance without materially correcting a bodily malfunction; or
- (b) to prevent or treat a Mental Sickness through a change in bodily form.

Community Mental Health Agency means an agency which:

- (a) is licensed as such by the proper authority of the state in which it is located;
- (b) has in effect a Plan for quality assurance and peer review; and
- (c) provides treatment under the supervision of a Physician or a licensed psychologist.

Covered Drug means:

- (a) a Drug or medicine which requires a Physician's written prescription;
- (b) insulin and certain diabetic supplies (needles, syringes, test tablets, sticks, tapes, strips and lancets); and
- (c) Contraceptive Drugs which require a Physician's written prescription.

Custodial Care means services or supplies, regardless of where or by whom they are provided which:

- (a) a person without medical skills or background could provide or could be trained to provide;
- (b) are provided mainly to help the Insured Person with daily living activities, including (but not limited to):
 - (1) walking, getting in and/or out of bed, exercising and moving the Insured Person;
 - (2) bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
 - (3) assistance with eating by utensil, tube or gastrostomy;
 - (4) homemaking, such as preparation of meals or special diets, and house cleaning;
 - (5) acting as a companion or sitter; or
 - (6) supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications;
- (c) provide a protective environment;
- (d) are part of a maintenance treatment Plan or are not part of an active treatment Plan intended to or reasonably expected to improve the Insured Person's Sickness, Injury or functional ability; or
- (e) are provided for the convenience of the Insured Person or the caregiver or are provided because the Insured Person's own home arrangements are not appropriate or adequate.

We will determine what services or supplies are Custodial Care. When a confinement in a facility or a visit to a Physician is found to be mainly for Custodial Care, some services (such as Prescription Drugs, x-rays and lab tests) may still be covered if Medically Necessary and otherwise covered by us. All bills should be routinely submitted for consideration.

Dental Injury means an Injury to Sound Natural Teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.

Dentist means a person who is licensed to practice in the state where the dental procedure is performed, operating within the scope of his or her license and performing a service which is payable under the Plan.

Where required to cover by law, Dentist means any other licensed practitioner who is acting within the scope of his or her license and performing a service which is payable under the Plan when performed by a Dentist.

A Dentist does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Developmental Care means services or supplies, regardless of where or by whom they are provided which:

- (a) are provided to an Insured Person who has not previously reached the level of development expected for the Insured Person's age in the following areas of major life activity:
 - (1) intellectual;
 - (2) physical;
 - (3) receptive and expressive language;
 - (4) learning;
 - (5) mobility;
 - (6) self-direction;
 - (7) capacity for independent living; or
 - (8) economic self-sufficiency;
- (b) are not rehabilitative in nature (restoring fully developed skills that were lost or; impaired due to Injury or Sickness); or
- (c) are educational in nature.

We will determine what services or supplies are Developmental Care. When a confinement, visit or other service or supply is found to be primarily for Developmental Care, some services or supplies (such as Prescription Drugs, x-rays and lab tests) may still be covered if Medically Necessary and otherwise covered by us. All bills should be routinely submitted for consideration.

Drug means any substance prescribed by a Physician taken by mouth; injected into a muscle, the skin, a blood vessel or a cavity of the body, or applied to the skin to treat or prevent a disease, and specifically includes Drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS.

Durable Medical Equipment means equipment which:

- (a) can stand repeated use;
- (b) is mainly and customarily used for a medical purpose;
- (c) is not generally useful to a person in the absence of an Injury or Sickness; and
- (d) is suited for use in the home.

It does not include equipment with a non-medical use, such as sun or heat lamps, heating pads, whirlpool baths, exercise devices, ramps or handrails, or air conditioners, purifiers, humidifiers, waterpiks or commodes.

Emergency Services means otherwise-covered health care services Medically Necessary to evaluate and treat a Medical Emergency condition, provided in a Hospital emergency department.

ERISA means the Employee Retirement Income Security Act of 1974, a Federal statute, which – together with other Federal laws and regulations – governs the administration of the Trust Fund and Benefit Plan.

Expense means the Expense incurred for a covered service or supply which has been ordered or prescribed by a Physician. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge:

- (a) for a service or supply which is not Medically Necessary; or
- (b) which is in excess of the usual and customary Global Charge for a service or supply.

Experimental or Investigational Drug, Device and Treatment or Procedure means a:

- (a) Drug or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and which has not been so approved for marketing at the time the Drug or device is furnished;
- (b) Drug, device, treatment or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a Drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function;
- (c) Drug, device, treatment, or procedure which Reliable Evidence shows is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
- (d) Drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.

Generic Drug means a Covered Drug, regardless of the manufacturer, which is bioequivalent to a Brand Name Drug and which is approved by the Federal Food and Drug Administration. Not all Brand Name Drugs have a generic equivalent.

Global Charge means the single Expense incurred for the combination of all necessary medical services normally furnished by a Physician or other covered provider (or multiple Physicians or other covered providers) before, during and after the principal medical service. The Global Charge will be based on a complete description of the covered medical service, rather than a fragmented description of that service. The Global Charge will not exceed the Usual and Customary Charge allowed by us. The determination of what is included in the Global Charge will be made by us.

Home Health Care Services means the services and supplies listed above, which are furnished:

- (a) by a Home Health Agency;
- (b) in the Insured Person's home; and
- (c) in accordance with a Home Health Care Plan.

Home Health Agency means a public or private agency or organization which:

- (a) administers and provides Home Health Care Services; and
- (b) is either:
 - (1) certified as such by the Washington Department of Social Services; or
 - (2) licensed or certified as such by the state where the services are rendered.

Home Health Care Plan means a plan of continued care and treatment of an Insured Person:

- (a) who is under the care of a Physician; and
- (b) whose Physician certifies that, without the home health care, confinement in a Hospital or skilled nursing care facility would be needed.

The Home Health Care Plan must be:

- (a) established by a Physician within 14 days after the home health care begins;
and
- (b) certified by a Physician every 30 days after the home health care begins.

Hospice Agency means a public or private agency or organization which:

- (a) administers and provides hospice care; and
- (b) is either:
 - (1) certified as such by the Washington Department of Social and Health Services;
 - (2) licensed or certified as such by the state where services are rendered;
 - (3) certified to participate as such under Medicare; or
 - (4) accredited as such by the Joint Commission on the Accreditation of Hospitals or the National Hospice Organization.

Hospice Care Services means palliative (pain controlling) and supportive medical, nursing and other health services provided:

- (a) by a Hospice Agency;
- (b) in the Insured Person's home or in an inpatient hospice unit or facility; and
- (c) in accordance with a Hospice Care Plan.

Hospice Care Plan means a plan of continued care of a Terminally Ill Insured Person who is under the care of a Physician:

- (a) which is established by a Physician within 14 days after the hospice care begins; and
- (b) which is certified by a Physician every 30 days after the hospice care begins.

Hospital means any of the following facilities which are licensed by the proper authority in the area in which they are located:

- (a) a place which is licensed as a general Hospital;
- (b) a place which:
 - (1) is operated for the care and treatment of resident inpatients;
 - (2) has a registered graduate nurse (RN) always on duty;
 - (3) has a laboratory and x-ray facility; and
 - (4) has a place where major surgical operations are performed; or
- (c) a facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative

nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for Mental Sickness/Alcohol and Drug Abuse and/or Substance Abuse, Hospital can also mean a place which meets these requirements:

- (a) has rooms for resident inpatients;
- (b) is equipped to treat Mental Sicknesses/Alcohol and Drug Abuse and/or Substance Abuse;
- (c) has a resident Physician on duty or on call at all times;
- (d) as a regular practice, charges the patient for the Expense of confinement; and
- (e) is licensed by the proper authority of the area in which it is located.

A Hospital does not include a Hospital or institution or part of a Hospital or institution which is licensed or used principally as a convalescent home, rest home, nursing home, home for the aged, halfway house onboard and care facility, residential treatment center (except as required under Chemical Dependency Benefits), “wilderness” program, treatment group home or “boot camp.”

Hospital Confinement means a Medically Necessary Hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board. How the Hospital classified the stay is irrelevant as well.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to inpatient Hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

Injury means an accidental bodily injury which is the direct result of a sudden, unexpected and unintended external force or element, such as a blow or fall that requires treatment by a Physician. It must be independent of Sickness or any other cause, including, but not limited to, complications from medical care.

Insured Person means you and/or your dependents who are covered under the Plan.

Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes:

- (a) temporomandibular joint dysfunction (TMJ), arthritis or arthrosis;
- (b) other craniomandibular joint disorders; and
- (c) myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Injury.

Legend Drug is a Drug which requires a Physician’s prescription in order to be dispensed.

Maintenance Drug means a Covered Drug which is prescribed for a chronic condition requiring continued medication on a regular or long-term basis.

Massage Therapy is the manipulation of the soft tissue of the body through stroking, rubbing, kneading or tapping to increase circulation, to improve muscle tone and to promote relaxation.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons.

Medical Emergency means the emergency and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in:

- (a) serious impairment to bodily functions;
- (b) serious dysfunction of a bodily organ or part;
- (c) placing the person's health in serious jeopardy;
- (d) the patient's portion of the difference between the cost sharing amounts for the use of preferred vs. non-preferred providers services will not exceed \$50;
- (e) if a non-participating hospital emergency department provides Emergency Services, benefits will be payable at the preferred provider level, provided:
 - (1) due to circumstances beyond the insured person's control, he or she was unable to go to a participating hospital in a timely fashion without serious impairment to his or her health; or
 - (2) a prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital in a timely fashion without serious impairment to his or her health.

A Medically Necessary service or supply means one which is ordered by a Physician and which we determine is:

- (a) provided for the diagnosis or direct treatment of an Injury or Sickness;
- (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Insured Person's Injury or Sickness;
- (c) provided in accordance with generally accepted medical practice on a national basis; and
- (d) the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care).

The fact that the Insured Person's Physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the Plan.

Mental Sickness/Alcohol and Drug Abuse and/or Substance Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded.

We may include special benefits for any one or more of the conditions included in this definition. If we do, only those special benefits relating to those conditions are available for that condition.

Naturopathic Care means a system of therapeutics in which neither surgical nor medical agents are used, dependent on being placed on natural (non medical) forces, such as:

- (a) natural foods;
- (b) light;

- (c) warmth;
- (d) massage;
- (e) fresh air;
- (f) regular exercise; and
- (g) the avoidance of medications.

Neurodevelopmental Therapies Services include services of those authorized to deliver Occupational Therapy, Speech Therapy and Physical Therapy. Such services shall be:

- (a) for the maintenance of a dependent child in cases where significant deterioration in the patient's condition would result without the service;
- (b) to restore and improve function; and
- (c) periodically reviewed by a Physician.

Occupational Therapy means treatment, when you or your dependent is physically Disabled, by means of constructive activities designed and adapted to promote the restoration of the ability to accomplish satisfactorily the ordinary tasks of daily living and those required by the particular occupational role of you or your dependent.

Off-Label means the prescribed use of a Drug which is other than that stated in its FDA approved labeling.

Other Provider means a provider of covered services who:

- (a) is not participating in our Preferred Provider option; and
- (b) is not shown on our current list of members in that option.

The payments to Other Providers will be based on the Usual and Customary Charges.

The Plan does not supervise, control or guarantee the health care services of any Preferred Provider or Other Provider.

Our, We, or Us means the Painters' Trust Health & Welfare Plan.

Out-of-Pocket Expense means Expense which the Insured Person incurs for covered services during the Calendar Year and must pay out-of-pocket:

- (a) to satisfy the deductible; or
- (b) as coinsurance (the percentage the Insured Person must pay in accordance with the percentage payable provision).

Peer-Reviewed Medical Literature means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.

Person With Diabetes means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes or elevated blood glucose levels induced by pregnancy.

Physical Therapy means treatment by:

- (a) manual manipulation or other physical means;
- (b) hydrotherapy;
- (c) heat;
- (d) physical agents; and
- (e) biomechanical and neurophysiological principles and devices;

used to:

- 1. relieve pain;
- 2. restore maximum bodily function; or
- 3. prevent disability arising from Injury or Sickness.

Physical Therapy shall not include cardiac rehabilitation

Physician means any of the following licensed practitioners who perform a service payable under the Plan:

- (a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- (b) a licensed doctoral clinical psychologist;
- (c) a master's level counselor and licensed or certified social worker;
- (d) a licensed Physician's assistant (PA); or
- (e) where required to cover by law, any other licensed practitioner who:
 - (1) is acting within the scope of his/her license; and
 - (2) performs a service which is payable under the Plan when performed by an MD.

A Physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Placed For Adoption means assumption and retention by the Insured Person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Plan means the provisions and benefits described in this booklet.

Preferred Prescription Drug Provider means a pharmacist who:

- (a) is participating in our Preferred Prescription Drug Provider option; and
- (b) is shown on our current list of members in that option.

Preferred Provider means a provider of covered services who:

- (a) is participating in our Preferred Provider option; and
- (b) is shown on our current list of members in that option.

The payments to Preferred Providers will be based on arrangements with providers who participate in the Preferred Provider option.

Prescription Drug means a Drug requiring a prescription by federal or state law will be provided when dispensed by a licensed pharmacist to treat a condition covered under the Plan. Antigen and

allergy vaccine and insulin dispensed by a Physician or certified laboratory will also be provided. Any other Drug or medication furnished by the Physician or any Drug not requiring a prescription will not be provided. Mail Order Drug purchases are limited to a 90-day supply.

Reconstructive Surgery means any surgical procedure which repairs an abnormal body structure.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, treatment or procedure.

Recipient means an Insured Person who undergoes a surgical operation to receive a Body Organ transplant.

Sickness means a disease, disorder or condition which requires treatment by a Physician.

1. For a female employee and dependent spouses, Sickness **includes** childbirth or pregnancy.
2. For a dependent child, Sickness **does not include** Normal Pregnancy or Normal Childbirth, but **it does include** Complications of Pregnancy.

Normal Pregnancy or **Normal Childbirth** means pregnancy or childbirth which is free of Complications of Pregnancy.

Complications of Pregnancy means:

- (a) any condition resulting in Hospital Confinement, the diagnosis of which is distinct from pregnancy, but is adversely affected or caused by pregnancy; or
- (b) a non-elective cesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, Physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not Complications of Pregnancy.

Smoking Cessation Services means treatment received in conjunction with tobacco usage, including chewing.

Speech Therapy means treatment for the correction of a speech impairment resulting from an Injury, Sickness or surgery, or such treatment following surgery to correct congenital and developmental anomalies. Speech Therapy is covered only if there is a Physician's recommendation that Speech Therapy is required for an Insured Person. Speech Therapy which is educational in nature, such as for treatment of a learning disability, is *not* covered.

Sound Natural Teeth means teeth which:

- (a) are whole or properly restored;
- (b) are without impairment or periodontal disease; and
- (c) are not in need of the treatment provided for reasons other than Dental Injury.

Spinal Treatment means detection or correction (by manual or mechanical means) of:

- (a) structural imbalance;
- (b) distortion; or
- (c) subluxation in the body;

to remove nerve interference or its effects. The interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Standard Reference Compendia means:

- (a) the American Hospital Formulary, Service-Drug Information;
- (b) the American Medical Association Drug Evaluation;
- (c) the United States Pharmacopoeia-Drug Information; or
- (d) other authoritative compendia as identified time to time by the Federal Secretary of Health and Human Services or the insurance commissioner.

Terminally Ill means:

- (a) determined by a Physician to have a terminal Sickness with no reasonable prospect of cure; and
- (b) expected by a Physician to have less than six months to live.

Total Disability, Totally Disabled or Disabled means that because of an Injury or Sickness:

- (a) You are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
- (b) Your dependent is:
 - (1) either physically or mentally unable to perform all of the usual and customary duties and activities (the “normal activities”) of a person of the same age and sex who is in good health; and
 - (2) not engaged in any work or occupation for wages or profit.

Union means the International Brotherhood of Painters, Decorators and Paperhangers of America and any other local Union affiliated with the International Brotherhood of Painters, Decorators and Paperhangers of America which may be added from time to time by mutual agreement between the Trust and us.

Usual and Customary Charge means a charge by a Professional Service Provider for a Covered Service which is no higher than the 90th percentile identified on the Healthcare Charges Database (HCD). When there is, in our determination, minimal data available from the HCD for a Covered Service, we will determine the Usual and Customary Charge by calculating the unit cost for the applicable service category using HCD, and multiplying that by the relative value of the Covered Service assigned by the Medicare Resource Based Relative Value Scale (supplemented with a commercially available relative value scale selected by us where one is not available from Medicare). In the event of an unusually complex Covered Service, a Covered Service that is a new procedure or a Covered Service that otherwise does not have a relative value that is in our determination

applicable, we will assign one. In no event will the Usual and Customary Charge exceed the amount billed by the Professional Service Provider or the amount for which the Insured Person is responsible. The term “Usual and Customary Charge” may not reflect the actual charges of the Professional Service Provider, and does not take into account the Professional Service Provider’s training, experience or category of licensure.

Women’s Health Care Practitioner means a person licensed under Washington state law to provide Women’s Health Care Services. It includes a licensed advanced registered nurse practitioner specialist in women’s health and midwifery.

Women’s Health Care Service includes, but is not limited to covered Medically Necessary maternity care, reproductive health services, gynecological care, general examination and medically appropriate preventive care, including follow-up visits.

It includes any appropriate care for other health problems, discovered and treated during the course of a visit to a Women’s Health Care Practitioner for a Women’s Health Care Service which is within the practitioner’s scope of practice.

It includes Medically Necessary laboratory, imaging, and diagnostic services, or prescriptions for Covered Drugs or covered medical supplies.

HOURLY EMPLOYEE ELIGIBILITY

Eligible Employees

Employees eligible for insurance under this Plan are Bargaining Unit Employees of Contributing Employers.

An employee is eligible for this coverage if he/she is an employee of a covered employer. A covered employer is an employer that subscribes to the Painters’ Trust.

If you are employed by more than one Contributing Employer, the amount of your benefits under the Plan will not exceed the amount for which you would have been insured if you were employed by only one such Contributing Employer.

Employees of Contributing Employers who do not provide the full contribution rate will have their benefits reduced proportionately.

Lag Month

In order that there is sufficient time for employer reports to be received and processed by the Administrative Office, a lag month is used in determining eligibility. For example: Hours worked in January are reported to the Trust in February, the Administrative Office determines eligibility in February (lag month) for March coverage.

Initial Eligibility

You will initially become eligible for benefits on the first day of the second calendar month following the calendar month in which you accumulate 300 hours in twelve consecutive months.

Example: If you work 160 hours in January and 160 hours in February, you will become eligible for benefits beginning the first of April. March is the “lag” month. All hours reported on your behalf by contributing employers are credited, to your “hour bank”.

Continuing Eligibility

There are two continuing eligibility plans available to members under the Trust. Your continuing eligibility is based on the contribution rate paid by your employer. You should contact the Trust Office to determine which plan is applicable to you.

There are two continuing eligibility provisions available to employees under the Trust which are determined by the contribution of each employer. These provisions are described below. You should contact the Trust Office to determine which provision is applicable to you.

Under both Plans described below, after you meet the initial eligibility you will continue to be eligible as long as you have at least 120 hours in your hour bank.

Plan I - The maximum number of hours that may be accumulated after deduction of the 120 hours is 450. This means that you can accumulate hours for up to 3 additional months of coverage.

Plan II - The maximum number of hours you can accumulate in your hour bank after deduction of the 120 hours is 810 hours. This means that you can accumulate for up to 6 additional months of coverage.

Plan I and Plan II Hour Banks

Hour Bank Plan	Local Union or Geographic Region
Plan I - accumulation up to 450 Hours	188, 260, 269, 427, 477, 567, 612, 995, 1034, 1140, 1237, 1555, 1726, 1922*, DC5 East Western Washington Painters, Oregon Painters, Las Vegas Material Handlers
Plan II - accumulation up to 810 Hours	159, 720, 764, 1922*, 1982 Western Washington Drywall, Tapers, Stripers Floor Coverers, Oregon Drywall

*Depends on bargaining agreement. Check with your Local or call the Trust Office.

Termination of Eligibility

Coverage will terminate at the end of the calendar month following the calendar month during which the employee’s hour bank accumulation is reduced to less than 120 hours, unless COBRA is elected. If your hour bank falls below 120 hours for 12 consecutive months, your hour bank becomes inactive. The hours credited in all inactive accounts revert to the Trust Fund.

After your hour bank becomes inactive, you must meet the initial eligibility rules to become covered.

Reinstatement of Eligibility

If your hour bank has not become inactive by falling below 120 hours for 12 consecutive months, as described above, you will be reinstated for eligibility when your hour bank shows at least 120 hours. Such reinstatement will become effective on the first day of the second calendar month following the month in which this requirement is met.

If your hour bank is below 120 hours for 12 consecutive months, all credited hours revert to the Trust Fund, and you must again complete the initial eligibility requirement for new employees to become eligible for coverage.

Example - Your coverage terminated January 31 with an hour bank of 90 hours. You work 40 hours with a contributing employer in October. Your eligibility is reinstated as of the first of December.

If you become Totally Disabled due to an occupational disability, while working for a Contributing Employer, your insurance, and insurance for your eligible dependents, will be continued for up to six months provided the disability commenced when you were eligible for insurance. Your hour bank will be frozen during that time. If you are still Disabled after six months, insurance will be continued for you and your dependents until your hour bank is exhausted.

If you become Totally Disabled due to a non-occupational disability, your insurance will be continued until your hour bank is exhausted.

Working for a Non-Participating Employer

Eligibility Frozen Notwithstanding any other provision or rule of this Plan, a Participant who is eligible for benefits and who works in non-covered service (defined below) shall have his or her eligibility suspended subject to the following rules:

1. An eligible Participant who works in non-covered service shall have his or her eligibility for benefits suspended and frozen effective on the first day of the next eligibility month following notification or information to the Plan that a Participant is employed in such non-covered service. Such eligibility and any hours bank reserves shall remain frozen until the second calendar month after he or she returns to employment in work described by and covered by a collective bargaining agreement which requires contributions to the Trust Fund. To re-instate frozen eligibility and hours bank reserves, such participant shall be required to earn at least the amount of covered hours required by the Plan to maintain continuing eligibility.
2. While a Participant's eligibility and hours bank reserves are frozen, no benefits or claims are payable with respect to any expenses incurred by the Participant or his or her dependents during the period coverage is frozen.
3. Unless such Participant re-instates participation as described in Section 1 above, such Participant's hours bank shall remain frozen for a period of 12 consecutive months at which time such account and any hours reserve shall be closed and the balance of the account shall be deemed waived and forfeited by the Participant.
4. Application of this rule shall have no effect upon a Participant's or beneficiaries COBRA rights.
5. "Non-covered service" is any work as described by and covered by a collective bargaining agreement to which the International Union of Painters and Allied Trades, and its affiliated local unions, are party within the geographic area covered by the Trust Fund but for which no employer contributions are required to be paid to the Plan.

Withdrawal or Termination of Bargaining Unit Participation Eligibility for covered benefits is available only to those employees who continue to work for an employer or employers who maintain a labor agreement which requires the payment of supporting contributions to the Employee Painters' Trust. A Participant's continuing eligibility under the hours bank eligibility system may be forfeited if (1) his or her signatory employer no longer maintains a labor agreement requiring contributions to the Trust Fund and/or (2) his or her local union bargaining unit withdraws participation in the Trust Fund.

Continuation of Coverage During Total Disability/Extension of Benefits For Medical and Prescription Drug Benefits

If you or your dependent is totally disabled by injury or sickness on the date eligibility ends, the Plan will extend Extension of Benefits for covered services as if eligibility had not ended up to a maximum of twelve (12) consecutive months from the date active eligibility ends or, if earlier, (a) the date you or your dependent becomes covered under another group health care plan; or (b) the date the total disability ends. Benefits payable are those in effect on the date eligibility ended.

This Extension of Benefits coverage period described above shall run concurrently with continuation coverage time periods available to you under COBRA if you elect the COBRA coverage (refer to COBRA GROUP HEALTH INSURANCE CONTINUATION found later on in this Certificate for a description of COBRA continuation coverage.) Under this Extension of Benefits provision, the Trust Fund shall pay on your behalf the first twelve (12) months of COBRA continuation premiums that are required to be paid for COBRA coverage. The election of COBRA will continue full eligibility for benefits for you and your dependents. Premium for COBRA coverage which continues after the expiration of the 12-month period must be paid by you or your dependent.

You must make the election for the COBRA coverage when your Active eligibility ends in order to utilize the COBRA coverage provision and for the Trust to make the COBRA payments on your behalf. If you do not elect COBRA, no COBRA payment will be made by the Trust and coverage will only be available under the Extension of Benefits. You will not be able to later elect COBRA coverage.

Retiree Medical Coverage

If you plan to retire, you may be eligible for coverage under the Retiree Medical Plan. Please note: You must make formal written application for the Retiree Medical Plan for you and your dependents at the time of your retirement and your application must be received in the Trust Administration office within 60 days of your retirement. Please contact the Trust Administration office for an application and copy of the Retiree Plan book.

FLAT RATE EMPLOYEE ELIGIBILITY

Company Participation Requirement

In order for you to be covered under the Flat Rate Plan, your employer must have signed a collective bargaining agreement calling for contributions to the Plan. Your employer must cover all employees in that unit. All flat rate employer and employee contributions must be remitted to the Trust Office by the 1st of each month following the month the hours are worked.

Your employer may cover himself and other employees who are not members of a collective bargaining agreement, provided he covers 100% of all such employees and agrees in writing to continue insurance throughout the life of the collective bargaining agreement.

Your employer may only insure employees who work directly for him under the rules set forth above. A non-union subsidiary of a participating employer will not be allowed to participate under the flat rate plan. Eligible employees may include office employees, maintenance employees, superintendents, production and/or industrial employees, provided the employer meets the rules and procedures established by the Trust. Please contact the Trust Office for a complete description of Plan benefits and rules for participation. **Not all employers provide all benefits available under the Trust. Please contact the Trust Office for verification of eligibility and benefits.**

The contribution required on behalf of flat rate employees will vary, depending upon the number of hours worked by Bargaining Unit Employees in the last year. If the owner/operator has reported 1,000 hours on behalf of bargaining unit members other than the owner/operator or his family, the current flat rate contribution in effect at the time will be continued for another 12 months.

If the owner/operator has not reported 1,000 hours for bargaining unit members, the new flat rate premium for that owner/operator will be the same as other bargaining unit members; 173 hours times the rate per contributions for the geographical area involved for the next 12 months.

Eligibility

You are eligible on the first day of the month following the calendar month in which you worked at least 80 hours at your regular job at your customary place of employment.

You will remain eligible as long as you continue to be actively employed.

Termination of Eligibility

Your insurance will terminate:

- (a) on the day the Plan terminates;
- (b) on the first of the month for which no employer or employee contributions are received;
- (c) on the day before you enter the Armed Forces on "active duty" (except for temporary active duty of two weeks or less); or
- (d) on the day in which you are no longer eligible under the Plan.

If you are eligible because of your employment, you will no longer be eligible when:

- (a) you resign or retire;
- (b) you go on leave of absence or strike;

- (c) you are dismissed, disabled, suspended, laid off, locked out or not working because of a work stoppage;
- (d) you are no longer in an eligible class; or
- (e) you do not satisfy:
 - (1) the requirements for hours worked; or
 - (2) any other eligibility conditions in this Plan.

DEPENDENTS ELIGIBILITY

Eligible Dependents

Only the following are eligible for dependents insurance:

- (a) your lawful spouse; (the Plan does not include domestic or same sex partners.)
- (b) your natural-born or legally adopted child;
- (c) your stepchild who is living in your home and is chiefly dependent on you for support; and
- (d) a foster child.

A foster child is:

- (1) a child you are raising as your own;
- (2) a child who lives in your home;
- (3) a child who is chiefly dependent on you for support; and
- (4) a child for whom you have taken full parental responsibility and control

A foster child is not:

- (5) a child temporarily living in your home;
- (6) a child placed with you in your home by a social service agency which retains control of the child; or
- (7) a child whose natural parent is in a position to exercise or share parental responsibility and control.

Adopted Child

A minor child, under the age of 19, Placed for Adoption with you will be insured from the moment the child is placed in your custody.

The child's insurance will continue until the earlier of:

- (a) the day the child is removed from your custody prior to legal adoption; or
- (b) the day insurance would otherwise end in accordance with the Plan provisions.

Qualified Medical Child Support Order

If your eligible child is not insured because you did not enroll your child for dependents insurance, such child may be enrolled after we:

- (a) receive a final medical child support order which requires enrollment; and
- (b) determine that the order is qualified.

Our Procedures for Determining if a Medical Child Support Order is Qualified

When we receive a proposed or final medical child support order, we will notify you and each child named in the order, at the addresses shown in the order, that we have received it. We will then review the order to decide if it meets the definition of a Qualified Medical Child Support Order. Within 30 days after we receive the order (or within a reasonable time thereafter), we will

give a written notice of our decision to you and each child named in the order. We will also send our notices to each attorney or other representative who may be named in the order or in other correspondence filed with us. If we decide that the order is not qualified, our notice will provide the specific reasons for our decision and the opportunity to correct the order or appeal our decision by contacting us within 30 days. If we decide that the order is qualified, our notice will provide instructions for enrolling each child named in the order, and the Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents insurance begins and the rules for determining when dependents insurance ends) will also apply for each child named in the order. We must receive a certified copy for the entire Qualified Medical Child Support Order before enrollment can occur. Also, if the cost of each child's insurance is to be deducted from your pay, the Plan must receive proper authorization in the order or otherwise.

As part of our authority to interpret the Plan, we have the discretion and final authority to decide if an order meets or does not meet the definition of a Qualified Medical Child Support Order so as to require the enrollment of your child as an eligible dependent; and our reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse medical Expenses paid by a child or the child's custodial parent or legal guardian, these benefits will be paid to the child or the child's custodial parent or legal guardian.

The Plan will treat each child enrolled because of a Qualified Medical Child Support Order as a participant for purposes of the reporting and disclosure requirements of a federal law known as ERISA.

A **Qualified Medical Child Support Order** is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

- (a) either:
 - (1) relates to medical benefits under the Plan and provides for your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or
 - (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
- (b) creates or recognizes the existence of your child's right to be enrolled and receive medical benefits under the Plan;
- (c) states the name and last known mailing address (if any) of you and each child covered by the order;
- (d) reasonably describes the type of medical insurance to be provided by the Plan to each child, or the manner in which this type of insurance is to be determined;
- (e) states the period to which the order applies;
- (f) states each Plan to which the order applies; and
- (g) does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

Dependents Not Eligible

The following are not eligible for dependents insurance:

- (a) your divorced spouse or any married child;
- (b) a child who has been legally adopted by another person (insurance ends on the date custody is assumed by the adoptive parents); or
- (c) a child who has attained the limiting age. The limiting age is:
 - (1) the child's 19th birthday; or
 - (2) the 23rd birthday if the child is a full-time student in any accredited high school, trade school, college or university and is chiefly dependent on you for support.

Handicapped Child

The insurance for a mentally or physically handicapped child who attains the limiting age while insured under the Plan may be continued if the child:

- (a) is chiefly dependent on you for support; and
- (b) is not capable of self-sustaining employment.

The insurance will continue only if you give us proof of the child's handicap;

- (a) no later than 31 days after the child attains the limiting age; and
- (b) thereafter as we may require, but not more often than once every two years.

When Dependents Insurance Begins

Dependents Insurance will begin the later of:

- (a) the day you are insured; or
- (b) the day you first acquire an eligible dependent.

Once you have a dependent insured, any newly acquired eligible dependents will be insured automatically.

Exceptions

Newborn children. Your newborn child, born while you are insured under the Plan, will automatically be insured; but insurance beyond 60 days for a newborn child will be continued only if any required premium is paid.

When Dependents Insurance Ends

A dependent's insurance will end at midnight on the earliest of:

- (a) the last day of the Plan month the dependent is no longer eligible;
- (b) the day the Plan ends;
- (c) the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less); or
- (d) the day your insurance ends.

**THE DEFINITIONS AND GENERAL EXCLUSIONS AND LIMITATIONS ARE
VERY IMPORTANT PARTS OF YOUR PLAN. PLEASE READ
THOSE PAGES CAREFULLY.**

**YOU, OR YOUR DEPENDENTS MUST BE ELIGIBLE FOR COVERAGE
WHEN THE SERVICE, CHARGE OR EXPENSE IS INCURRED.**

SCHEDULE

For you

Accidental Death and Dismemberment Benefits

Principal Sum.....\$10,000

For you

Weekly Disability Benefit

Benefit

Amount is determined by the bargaining agreement:

\$150 or \$500 per week, up to a maximum of 26 weeks for any one period of disability

NOTE: Some Flat Rate employers do not contribute to this benefit. you should confirm your eligibility for this benefit with the Trust Office.

UTILIZATION MANAGEMENT

Care Management Program

The Care Management Program requires you, your representative, your doctor and/or hospital to take certain steps when an inpatient confinement is recommended. Before the services or supplies are received, all Hospital Confinements must be precertified as Medically Necessary. You, not your Physician, are responsible for making sure precertification occurs. However, you, your representative or your Physician may initiate the precertification.

What does the Care Management Program do for you?

- It helps you work with your doctor or other health care providers to ensure that your medical services are Medically Necessary under the terms of the Plan.
- It will monitor your hospitalizations to ensure that you receive treatment in the least costly manner.
- It will assist in your hospital discharge planning and see that you receive appropriate medical support services following your discharge, when necessary.
- It allows the Plan to manage health care services and cost more efficiently to ensure that your high level of benefits can continue.

CareAllies Hospital Precertification

All inpatient hospitalization except for emergency care and childbirth (unless the stay is for greater than 48 hours for normal delivery or 96 hours for Caesarean) require precertification. To precertify, you must call CareAllies at 1-800-932-7766 as soon as you know you are going to be hospitalized. If an emergency admittance, you, your representative or the hospital must call within two (2) business days following the admittance or as soon as reasonably possible.

Precertification of a Hospital Confinement as Medically Necessary through the Utilization Review process does not necessarily mean that benefits are payable. Confirmation of an insured person's eligibility for Plan coverage for a particular service or supply and fulfillment of all other Plan requirements are also necessary for benefits to be payable. A determination will be made regarding the medical necessity of your inpatient treatment and you will receive a letter indicating the number of hospital days certified.

Also, unless you have a medical emergency, you should make the call yourself and not rely on your doctor or the hospital to precertify your hospital stay for you.

Medical Review While Hospitalized

During an approved hospitalization, the Plan will monitor the confinement to assure that continued general hospital care is medically necessary and that the services being provided are appropriate to the condition being treated. Your doctor will be advised of alternatives to hospitalization, such as home care services, which may promote an earlier discharge and recovery at home.

If you Have Questions Regarding the Care Management Program

If you have questions regarding the Care Management Program, your doctor or hospital should call CareAllies. If you have questions regarding the Plan, you should call the Administrative Office. When calling, please identify yourself as a participant in the Employee Painters' Health and Welfare Trust.

Administrative Office
(509) 534-0265 or (800-566-4455) or
Care Management Program CareAllies
1-800-932-7766

Request For An Appeal Of The Utilization Review Decision

You, your representative or your provider of health care have the right to request an appeal regarding the Utilization Review decision. The request should be submitted in writing and should include any additional information that may have been omitted from the review or that should be considered by us.

The request should be sent to:

Care Management Program
CareAllies
c/o Zenith Administrators, Inc.
104 S. Freya, Suite 220
Spokane, WA 99202

You may also call the Care Management Program's toll free phone number listed on your insurance identification card for additional information regarding the appeal.

Exceptions

Precertification is not required when the Insured Person is a retiree or a dependent of a retiree and/or has Medicare coverage which has primary responsibility for the Insured Person's claims and which must pay its full benefits before Plan benefits are paid in accordance with the Coordination of Benefits provision.

Precertification is not required when an Insured Person has other group medical coverage which has primary responsibility for the Insured Person's claims and which must pay its full benefits before Plan benefits are paid in accordance with the Coordination of Benefits provision.

Precertification is not required when the Insured Person receives services or supplies outside of the United States, Mexico, Canada, or any state, district, province, territory or possession thereof.

**ACTIVE EMPLOYEES OTHER THAN MATERIAL
HANDLERS FOR YOU AND YOUR DEPENDENTS
MAJOR MEDICAL BENEFITS**

DISCOUNTED CHARGES

We have contractual arrangements with Preferred Providers and other health care providers, provider networks, pharmacy benefit managers, and other vendors of health care services and supplies (“Providers”). In accordance with these arrangements, certain Providers have agreed to Discounted Charges.

A “Discounted Charge” is the amount that a Provider has agreed to accept as payment in full for covered health care services or supplies. A “Discounted Charge” does not include pharmaceutical rebates or any other reductions, fees or credits a Provider may periodically give us. We will retain those amounts that are not “Discounted Charges.” However, we have estimated the amount of such rebates, reductions, fees and credits and have taken those into consideration in setting the premium charged to provide insurance under this Plan.

Claims under the Plan and any Deductible, Co-payment (based upon percentage of charge), Coinsurance and benefit maximums as described in this Schedule will be determined based on the Discounted Charge.

Percentage Payable

After the deductible is satisfied, we pay 80% of the Expense which the Insured Person incurs for covered services (and the Insured Person pays 20%), until the stop-loss limit is reached.

NOTE: Members in Alaska must use Alaska Regional Hospital or Charter North Hospital to obtain full benefits and discounts. Use of any other hospitals in Anchorage will result in a 40% reduction in benefits. Please note that this is for hospital services only and physician’s charges are not affected with this arrangement.

Out-of-Pocket

After the Out-of-Pocket Expense by one Insured Person reaches \$1,300 (including the deductible and any coinsurance), we pay 100% of the Expense which that Insured Person incurs for covered services for the rest of the Calendar Year.

Deductible

Individual Deductible

\$300 of Expense incurred for covered services. The Insured Person must satisfy the deductible once each Calendar Year.

Family Deductible

After \$900 for all Insured Persons in your family has been satisfied in the same Calendar Year, no other Insured Person in your family needs to satisfy the deductible in the same Calendar Year.

The deductible applies to all benefits except Preventive Care and Routine Benefits.

Exceptions

- (a) Deductible Carry-over. The Deductible is reapplied on January 1 of each year. However, Expense applied towards the Deductible in the last 90 days of a Calendar Year will be applied towards the Deductible for the next Calendar Year.
- (b) Common Accident Deductible. If two or more Insured Persons of your family are injured in the same accident, we will apply only one Deductible for that accident. This Common Accident Deductible will also apply to any reapplications of the Deductible for that accident.

Maximum

\$1,000,000 for all Injuries or Sicknesses for each Insured Person. Benefits are payable only for Expense incurred while you or your eligible dependents are insured under the Plan or are entitled to benefits under the major medical extended benefits provision.

Restoration of Maximum

After at least \$1,000 of benefits has been paid for Expenses incurred by any one person, \$1,000 will automatically be added to the balance of the maximum the first of each Calendar Year until the original maximum is reinstated. Furthermore, at any time after benefits have been paid under this provision, the maximum may be restored to its entirety by providing evidence of good health acceptable to us.

Room Limit

Semiprivate Room: The semiprivate room charge of the Hospital where the Insured Person is confined.

Ward Accommodation: The ward accommodation charge of the Hospital where the Insured Person is confined.

Private Room: The average semiprivate room charge of the Hospital where the Insured Person is confined.

Intensive Care Unit/Cardiac Care Unit: The intensive care unit/cardiac care unit charge of the Hospital where the Insured Person is confined.

Mental Sickness Benefit

Maximum Inpatient and Outpatient Benefit

Inpatient Benefits - up to 10 days per Calendar Year. Outpatient Benefits – up to 20 visits per Calendar Year.

Hearing Aid Benefit Maximum

We will pay benefits in the same manner as any other Sickness, up to \$350 per each ear in any period of 36 consecutive months.

Chemical Dependency Benefit Maximum

Maximum is the greater of:

- (a) \$13,000; or
- (b) \$13,000 plus any adjustment based upon a change in the medical care component of

the consumer price index for all urban consumers for the Seattle Standard Metropolitan Statistical Area compiled by the Bureau of Labor statistics, United States Department of Labor;

during a 24-month period.

Preventive Care Benefit Maximum

We will pay 100% of the Expense incurred with no deductible, up to \$300 per Insured Person per Calendar Year.

Well Child Care

We will pay 100% of the Expense incurred with no deductible, up to \$2,500 per Insured Child through the age of 24 months.

Alternate Provider Benefit

We will pay up to 24 visits each for services for Acupuncture, Massage Therapy and Naturopathic Care per Calendar Year.

PRESCRIPTION DRUG BENEFITS

For Preferred Providers

Retail (includes claim form)

For Covered Drugs:

The Insured Person pays a Co-payment for each prescription or refill. After the Co-payment is satisfied, we pay 100% of the Expense incurred.

The Co-payment amount does not apply to the medical plan deductible or out-of-pocket amounts and will not be reimbursed under the medical Plan.

20% for Generic Drugs

25% for Brand Name Drugs when Generic Drugs are not available

50% for Brand Name Drugs when Generic Drugs are available

up to a 30-day supply for each prescription.

The \$5,000 family out-of-pocket maximum applies separately to Mail Order and Retail Plans.

Mail Order

20% Co-payment for Generic Drugs;

25% Co-payment for Brand Name Drugs when Generic Drugs are not available;

50% for Brand Name Drugs when Generic Drugs are available;

up to a 90-day supply for each prescription.

The \$5,000 family out-of-pocket maximum applies separately to Mail Order and Retail Plans.

Reimbursement Plan

80% after the Deductible subject to the Medical Plan out-of-pocket limit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For You

Benefits

If you are accidentally injured, and that Injury is independent of Sickness and all other causes, we will pay the benefit shown below for any of the following losses:

Loss	Eff 1/1/07
Life.....	\$10,000
Both hands, both feet or both eyes.....	\$10,000
One hand and one foot, one hand and one eye, or one foot and one eye.....	\$10,000
One hand, one foot or one eye	\$ 5,000
Thumb and index finger of same hand.....	\$ 2,500

Loss of a hand means the severance at or above the wrist joint.

Loss of a foot means the severance at or above the ankle joint.

Loss of thumb and index finger means the severance of two or more phalanges of both the thumb and the index finger.

Loss of an eye means the total loss of sight in that eye.

If the Injury causes more than one loss, we will pay only the largest benefit.

Benefits payable under this provision for any loss other than life will be paid to you in a lump sum.

Payment for Loss of Life

Beneficiary

Benefits payable under this provision because of your death will be paid to the beneficiary you name. If you have not named a beneficiary, or if your named beneficiary does not survive you, the benefits will be paid to the person or persons in the following order of priority:

- (a) spouse;
- (b) natural or adopted child or children;
- (c) parent or parents;
- (d) brothers or sisters; or
- (e) your estate.

Benefits will be paid equally among surviving beneficiaries unless you have requested otherwise in writing.

Mode of Payment

We will pay death benefits:

- (a) in a lump sum; or
- (b) in other than a lump sum if:
 - (1) another mode of payment is requested as described below; and
 - (2) we agree to it in writing.

Beneficiary or Mode of Payment Change

The beneficiary or mode of payment may be changed at any time, unless this right has been given up. To make a change, a written request should be sent to the Trust Office where the beneficiary records are kept. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken before the request was acknowledged by us.

Definition

Traveling on Business of the Plan means any trip made by you on assignment by or with authorization of the Plan for the purpose of furthering the business of the Plan.

Exceptions

We will not pay for any loss which:

- (a) is not permanent;
- (b) occurs more than 365 days after the Injury;
- (c) is caused by voluntary carbon monoxide poisoning;
- (d) results from injuries you receive in any aircraft other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight or while:
 - (1) operating;
 - (2) riding as a passenger in; or
 - (3) boarding or leaving;

any aircraft while you are Traveling on Business of the Plan, provided the aircraft:

- (1) has a current and valid FAA (Federal Aviation Administration of the United States) standard airworthiness certificate; and
- (2) is operated by a person holding a current and valid FAA pilot's certificate of rating authorizing him or her to operate the aircraft;
- (e) results from Injuries you receive while riding in any aircraft engaged in:
 - (1) racing; or
 - (2) acrobatic or stunt flying;
- (f) is caused by bodily or mental infirmity, ptomaines, bacterial infections (except pyogenic infections sustained accidentally) or which is caused by any other kind of disease; or
- (g) is excluded under the General Exclusions and Limitations.

WEEKLY DISABILITY BENEFITS

For You

Benefits

If you become Totally Disabled by Injury or Sickness while you are eligible and covered under active coverage, we will pay while you remain Totally Disabled:

- (a) at the rate of the **Weekly Benefit** shown in the **Schedule**; and
- (b) up to the **Maximum Weeks Payable** shown in the **Schedule** for a period of disability.

Benefits begin on the first day of disability due to an accident, and the eighth day of disability due to Sickness. No benefits will be paid for any period of disability during which you are not under the care of a Physician or receiving compensation from any other sources.

The benefit amount for which you are eligible is determined by the Collective Bargaining Agreement with your employer.

New Period of Disability

Weekly Disability Benefits shown in the Schedule will be restored each new period of disability.

A new period of disability begins:

- (a) when you become Disabled after you have been back to work full-time for at least 10 consecutive working days since the previous disability; or
- (b) when you become Disabled due to a cause not related to any cause of the previous disability, and the new disability begins after you have been back to work full-time for at least one day.

No extension options are available for this benefit.

Exceptions

We will not pay for:

- (a) any disability during which you are not under the regular care of a Physician; or
- (b) anything excluded under the General Exclusions and Limitations; or
- (c) any disability that began while you are on COBRA.

Taxation of Benefits

Benefits paid by the Plan are subject to Social Security (FICA) taxation. The Plan is required by federal law to withhold and deposit with the appropriate depository your share of the tax from each weekly disability benefit payment.

Weekly disability benefits provided by the Plan are also subject to federal income tax. You have the option of having the Trust withhold federal income taxes from your weekly benefit. At year end, the Plan will send you a W-2 form so that you will be able to file your federal income taxes.

If you want federal income taxes withheld, contact the Trust Office and request form W4S.

MAJOR MEDICAL BENEFITS

For You and Your Dependents

The Painters' Trust has implemented a Preferred Provider plan through First Choice for Hospital care and Physician services. (In Oregon, Managed Healthcare NW) and (in Nevada, it is through Sierra Healthcare Options). (Alaska members must use Alaska Regional or Charter North Hospitals to avoid penalties). You will be provided with an identification card which will identify you as being covered through the Preferred Provider plan.

Not all providers listed in the directory are covered by the Plan and some may be covered only under certain benefits or certain circumstances. The Plan does not supervise, control or guarantee the health care services of any provider.

Benefits

If you or your dependent incurs Expense for Covered Services because of an Injury or Sickness, we will pay a percentage of that Expense after the deductible is satisfied. We will pay up to the Maximum for each Insured Person. The **Percentage Payable, Deductible** and **Maximum** are shown in the **Schedule**.

Covered Hospital Services

We will pay Expenses for:

- (a) Hospital room and board, up to the **Room limit** shown in the **Schedule**;
- (b) Hospital services and supplies used when benefits are payable under (a) above.

Hospital charges for the services of a Physician, private duty nurse or other practitioner are not covered under (a) or (b) above;

- (c) Hospital outpatient services in connection with:
 - (1) a surgical operation; or
 - (2) emergency treatment **within 48 hours** after an accident; and
- (d) preadmission tests for surgery which are:
 - (1) given within 72 hours of admission as a resident patient;
 - (2) ordered by a Physician;
 - (3) performed on you or your dependent at the Hospital; and
 - (4) necessary for and consistent with the reason for which surgery is to be performed.

Covered Surgical Services

We will pay Expenses for:

- (a) Physician's services for an operation, or the repair of a dislocation or fracture; and
- (b) administration of anesthesia by persons not employed by the Hospital.

Other Covered Services (if not included above)

We will pay Expenses for:

- (a) Hospital outpatient services;
- (b) Physician's services for medical care;
- (c) active services of an assisting surgeon;
- (d) services of a registered graduate nurse (RN) for private duty nursing care, or of a licensed physiotherapist; but we will not pay for services provided by a person who lives with you in your home or is a part of your family;
- (e) Physical and occupational therapy will be limited to 60 visits per calendar year and speech therapy will be limited to 30 visits per calendar year;
- (f) ambulance services for:
 - (1) local professional ambulance service; and
 - (2) transportation by professional ambulance or on a regularly scheduled flight on a commercial airline when:
 - a. special and unique Covered Hospital Services are required which are not provided by a local Hospital;
 - b. transportation is Medically Necessary; and
 - c. transportation is to the nearest Hospital equipped to furnish the services; and
- (g) the following services and supplies:
 - (1) formulas necessary for the treatment of phenylketonuria (PKU). (Benefits payable for PKU are not subject to any Preexisting Condition exclusion or limitation);
 - (2) diagnostic x-ray and laboratory service. Also included is one routine pap smear per Calendar Year (including Physician's charges) and routine mammograms recommended by a Physician or a Physician's assistant and one prostate exam (including Physician's charges) not subject to the deductible;
 - (3) Women's Health Care Services because of an Injury or Sickness. Any Women's Health Care Practitioner may be chosen for the covered service, **provided the services are otherwise covered under the Plan;**
 - (4) oxygen and the rental of equipment for its administration;
 - (5) blood or blood plasma and its administration;
 - (6) radium, radioactive isotopes and x-ray therapy;
 - (7) casts, splints, braces, trusses and crutches;
 - (8) Durable Medical Equipment used for the treatment of a covered Injury or Sickness;
 - (9) artificial limbs and eyes to replace natural limbs and eyes;
 - (10) initial placement of contact lenses required because of cataract surgery;
 - (11) dental services by a Physician or Dentist for the treatment of a Dental Injury to Sound Natural Teeth, (including the initial replacement of the injured teeth and any necessary dental x-rays), provided the Expense is incurred within one year after the Injury;
 - (12) sterilization procedures and elective abortions for employees and spouses; and
 - (13) prescription drugs for which a Physician's written prescription is required in order to obtain.

NOTE: If you or your dependent are Medicare eligible and are enrolled in a Medicare Part D prescription drug plan, outpatient prescription drug benefits will not be provided under this Plan.

Home Health Care Benefits

If you or your dependent incur Expense for covered Home Health Care Services, we will pay:

- (a) major medical benefits at 100% for other covered services; but
- (b) not to exceed 130 visits in any Calendar Year for the services listed in (a) through (d) below.

Each visit by a member of the Home Health Care team will be considered one Home Health Care visit.

Covered Home Health Care Services

We will pay Expenses for:

- (a) skilled nursing care provided on a part-time basis (no more than an eight-hour shift) by:
 - (1) a registered nurse; or
 - (2) a licensed practical nurse (LPN);
- (b) Physical Therapy, Occupational Therapy, inhalation therapy or Speech Therapy provided by a licensed therapist;
- (c) home health aide services provided on a part-time basis (less than an eight-hour shift) which:
 - (1) are performed by a home health aide under the supervision of a registered nurse (RN) or a licensed therapist;
 - (2) consist mainly of medical care and therapy for the Insured Person; and
 - (3) may include helping the Insured Person with:
 - a. personal care;
 - b. taking medications;
 - c. movement or exercise; and
 - d. making reports on the Insured Person's condition;
- (d) medical social services provided by a licensed social worker with a master's degree in social work;
- (e) ambulance service which is:
 - (1) certified by a Physician to be necessary because of the Insured Person's medical condition; or
 - (2) required because of a Medical Emergency; and
- (f) the following equipment and supplies, which are ordered or prescribed by a Physician and would be covered as a Hospital inpatient Expense:
 - (1) Drugs and medicines requiring a Physician's written prescription (and insulin);
 - (2) medical supplies such as oxygen, catheters, syringes, dressings, antiseptics, irrigation solutions and intravenous fluids;
 - (3) prosthetic devices, casts, splints, trusses, crutches and braces; and
 - (4) rental (up to the purchase price) of a wheelchair, Hospital bed for patient care or other Durable Medical Equipment.

Benefits for such equipment and supplies will be paid in the same manner as when they are provided while the Insured Person is confined to a Hospital.

Hospice Care Benefits for a Terminally Ill Person

If you or your dependent incurs Expense for Hospice Care Services because of a terminal Sickness, we will pay major medical benefits at 100%, but:

- (a) not to exceed 6 months of inpatient and outpatient Hospice Care Services combined while insured under the Plan; and
- (b) not to exceed a daily benefit which:
 - (1) for inpatient hospice care equals the semiprivate room rate; and
 - (2) for outpatient hospice care equals 50% of the semiprivate room rate;

of any Hospital, skilled nursing care facility or convalescent home which is associated with the hospice (or, if none, which is located nearest the hospice).

Payment of hospice care benefits is not in lieu of Hospital or medical benefits under the Plan; but we will not pay duplicate benefits for the same services and supplies or the same days of confinement.

Exceptions for Home Health Care and Hospice Care

We will not pay for:

- (a) services and supplies which are not covered under this home health care benefit and hospice care benefit;
- (b) services by a person who lives in your home or is a member of your family;
- (c) services which consist mainly of housekeeping, companionship or sitting;
- (d) services which are not directly related to the Insured Person's medical condition, including (but not limited to):
 - (1) estate planning, drafting of wills or other legal services;
 - (2) pastoral counseling or funeral arrangements or services;
 - (3) nutritional guidance or food services such as "meals on wheels;" or
 - (4) transportation services (except as provided above); or
- (e) Expense for which benefits are paid under any other provision of the Plan.

Any requirement that Hospice Care be part of an active plan of medical treatment which is reasonably expected to reduce the disability will not apply.

Mental Sickness Benefits

Benefits provided under the Plan for the treatment of a Mental Sickness will include treatment by:

- (a) a Physician;
- (b) a licensed psychologist;
- (c) a Community Mental Health Agency; or
- (d) a state Hospital;

subject to such providers being licensed by the proper authority of the state in which they are located.

If an employee or dependent incurs covered charges because of a Mental Sickness, the benefits for any inpatient or outpatient Medically Necessary treatment and supporting services will be paid in the same manner as any other Sickness.

Inpatient services will be payable up to 10 days per Calendar Year.

Outpatient services will be payable up to 20 visits per Calendar Year.

Jaw Treatment Benefits

We will pay limited benefits for surgical and non-surgical treatment by a Physician or a Dentist for:

- (a) temporomandibular joint (TMJ) dysfunction;
 - (b) myofascial pain dysfunction (MPD); and
 - (c) jaw surgeries of any nature;
- including skeletal deformities, except treatments relating to tumors or malignancies.

Coverage includes:

- (a) diagnosis;
- (b) x-rays;
- (c) hospitalization;
- (d) surgery;
- (e) physical therapy;
- (f) splints; and
- (g) guards.

We will pay benefits in the same manner as any other Sickness for covered charges up to a maximum of \$5,000 while insured under the Plan. Charges in excess of these benefits do not apply to the annual “out-of-pocket” maximum.

Regular Plan benefits will apply to jaw surgery or repair if the required treatment is for an Injury resulting from an accident. These benefits require treatment to be started within the 12 months immediately following the accident. Failure to commence treatment within this time shall not invalidate any claim if it can be shown that it was not reasonably possible to commence the treatment within the 12-month period, and the treatment was commenced as soon as reasonably possible.

Spinal Treatment Benefits

If an Insured Person incurs Expenses for home and office calls to a Physician or surgeon as a result of Spinal Treatment, we will pay for 24 visits per Calendar Year up to a considered maximum benefit payable of \$20 per visit. X-rays are paid the same as any other condition.

Chemical Dependency Benefit

Definition

Medically Necessary, with respect to Chemical Dependency coverage, means indicated in the most recent Patient Placement Criteria for the Treatment of Substance-Abuse-Related Disorders II as published by the American Society of Addiction Medicine.

Chemical Dependency means for the purposes of an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Benefits

1. If you or your insured dependent requires Medically Necessary detoxification in a Hospital or other licensed facility as a result of Chemical Dependency, we will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Sickness.

Such detoxification care:

- (a) is considered a Medical Emergency under the Plan; and
 - (b) as long as the patient is not yet enrolled in other Chemical Dependency treatment, is not included when calculating the Chemical Dependency payment maximum described in item 2 below.
2. If you or your insured dependent enrolls in a state-approved treatment program, for the Medically Necessary treatment of Chemical Dependency, we will pay the Expense incurred, including supporting services, in the same manner and subject to the same conditions and limitations as any other Sickness, but not to exceed \$12,500, during any consecutive 24-month period.

Note: Each January 1 following January 1, 2005, the benefit amount will increase by \$500.

Court-ordered Chemical Dependency treatment is not covered under this provision unless it is Medically Necessary.

Notice Requirement

In situations where an Insured Person is under court order to undergo a Chemical Dependency assessment or treatment which:

- (a) is related to deferral of prosecution;
- (b) is related to deferral of sentencing or suspended sentencing; or
- (c) pertains to motor vehicle driving rights and the Washington State Department of Licensing;

We will require, at the Insured Person's expense, and no less than 10 and no more than 30 working days before treatment is to begin:

- (a) an initial assessment of the need for Chemical Dependency treatment; and
- (b) a treatment plan;

made by a certified Chemical Dependency counselor of the Insured Person's choice who is employed by a state-approved treatment program. This will enable us to make our own determination that the scheduled treatment is Medically Necessary.

Alternate Provider Benefits

If an Insured Person incurs Expense for a covered service because of an Injury or Sickness for Naturopathic Care, Acupuncture treatment or Massage Therapy by an acupuncturist, massage therapist or naturopath we will pay benefits as shown in the Schedule.

Hearing Aid Services Benefit

If you or your dependent incurs Expense by a Physician or a certified or licensed audiologist for covered Hearing Aid Services, we will pay for the Expense incurred up to the Hearing Aid Benefit Maximum shown in the Schedule.

We will pay Expenses for the following:

- (a) an otologic examination made by a Physician;
- (b) an audiologic examination made by a certified or licensed audiologist and the Expense for one follow-up visit; and
- (c) the purchase of a hearing aid device (monaural or binaural) prescribed as a result of such examinations, but only if the examining Physician or audiologist certifies that the Insured Person has a hearing loss that may be lessened by the use of a hearing aid device. These charges include the Expense for:
 - (1) the actual hearing aid device;
 - (2) ear mold(s);
 - (3) the initial batteries, cords and other necessary ancillary equipment;
 - (4) a warranty; and
 - (5) a follow-up visit within 30 days after the delivery of the hearing aid device.

Exceptions

We will not pay for:

- (a) replacement of a hearing aid more than once during any period of 36 consecutive calendar months, regardless of the reason;
- (b) batteries or other ancillary equipment, except those purchased with the hearing aid device;
- (c) repairs, servicing or alterations of hearing aid equipment;
- (d) a hearing aid device that exceeds the specifications of the prescription;
- (e) service or supply that is not necessary or that does not meet professionally recognized standards; or
- (f) anything excluded under the General Exclusions and Limitations.

Extension of Hearing Aid Benefits

No benefits will be paid for Expense incurred after the date an Insured Person's insurance ends other than Expense for a hearing aid device that was ordered prior to and delivered within 30 days after the termination date.

Phenylketonuria (PKU) Treatment Benefits

Formulas necessary for the treatment of phenylketonuria (PKU) are payable as any other covered service.

This benefit provision is not subject to any preexisting condition exclusion or limitation in the Plan.

Neurodevelopmental Therapies Services

If a dependent child six years of age and under incurs Expense for Neurodevelopmental Therapies Services, we will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service, but not to exceed \$2,000 while insured under the Plan.

Exceptions

We will not pay for:

- (a) any Neurodevelopmental Therapies Services when the dependent child is over six years of age; or
- (b) any Expense which is paid under any other provision of the Plan.

Routine Benefits

If you or your dependent incurs Expense for the following services, we will pay 100% of the Expense incurred, but not to exceed \$300 each calendar year (except benefits for #4) for all routine preventive care services combined. Any deductible shown in the Plan will not apply.

Benefits for routine pap tests and routine prostate test, including Physician charges, are paid as a separate benefit under the medical plan.

1. Routine Physical Exam Benefits (For Insured Persons Age 24 Months or Older). A routine physical exam performed in:

- (a) a Hospital outpatient department; or
- (b) a Physician's office or clinic;

including any related laboratory and x-ray charges for the routine physical exam.

2. Routine Cancer Screening Benefits. Expense incurred for routine screening procedures for cancer.

3. Smoking Cessation Benefits. Smoking cessation benefits for:

- (a) nicotine patches or any other smoking deterrent which requires a Physician's written prescription; and
- (b) a behavioral modification program (other than hypnosis) attended in conjunction with the nicotine patch or other smoking deterrent;

for treatment received in conjunction with tobacco usage, including chewing, is covered, provided:

- (a) the nicotine patch or other smoking deterrent used is in conjunction with a behavioral modification program; and
- (b) we receive the Physician's written certification that the program was completed.

4. Preventive Health Care Services (For Dependent Children through the Age of 24 Months).

If your dependent child incurs Well Child expense for the following services, we will pay 100% of the covered expense incurred, but not to exceed \$2,500 in the first two years of the child's life. Preventive health care services in a Hospital outpatient department, Physician's office or clinic, for:

- (a) a Physician's preventive health care services; and
- (b) preventive inoculations, which include:
 - (1) inoculations for diphtheria, tetanus, pertussis, measles, mumps and rubella;
 - (2) oral polio vaccine; and
 - (3) tests for tuberculosis.

Exceptions

We will not pay for:

- (a) a routine physician exam performed while the Insured Person is confined as a resident patient in a Hospital;
- (b) Preventive Health Care Services performed while a dependent child is confined as a resident patient in a Hospital; or
- (c) any Expense which is paid under any other provision of the Plan.

Off-Label Use Of Drug Benefits

If you or your dependent incurs Expense for Drugs, including their administration, which have not been approved by the federal Food and Drug Administration (FDA) for a particular indication, we will pay the Expense incurred on the same basis as any other Covered Drug, provided the Drug is recognized as effective for treatment of such indication:

- (a) in one of the Standard Reference Compendia;
- (b) in the majority of relevant Peer-Reviewed Medical Literature if not recognized in one of the Standard Reference Compendia; or
- (c) by the Federal Secretary of Health and Human Services.

Exceptions

We will not pay for:

- (a) any Drug when the FDA has determined its use to be contraindicated;
- (b) Experimental Drugs not otherwise approved for any indication by the FDA; or
- (c) anything excluded under the General Exclusions and Limitations; however, any exclusion that is in conflict with the benefits provided by this provision will not apply.

Prenatal Testing for Congenital Disorders

If a female Insured Person incurs Expense for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures, benefits will be payable under the Plan in the same manner as for any other Sickness.

Maternity Benefits

If an Insured Person is confined to a Hospital as a resident inpatient for childbirth, including any post delivery follow-up care, we will pay benefits in the same manner and subject to the same conditions and limitations as any other Covered Service. Benefits will be in accordance with accepted medical practice as recommended by the attending Physician (including a licensed nurse midwife, a licensed Physician's assistant, or a licensed advanced registered nurse-practitioner), in consultation with the mother.

Post delivery follow-up care includes, but is not limited to, visits by a licensed home health agency or by a licensed registered nurse.

The newborn child will be insured automatically for three (3) weeks following birth, even if the newborn child is admitted separately to the Hospital. Following such three-week period, the newborn child will be insured in accordance with the Dependent Eligibility provisions of the Plan.

Condition

Benefits will be payable only if the Insured Person's pregnancy is insured under the Plan.

Diabetes Benefits

1. If you or your dependent is a Person With Diabetes and incurs Expense for the following diabetes equipment and supplies for the treatment of diabetes, benefits will be paid in the same manner and subject to the same conditions and limitations as any other covered service.

Diabetes Equipment and Supplies includes but is not limited to:

- (a) blood glucose monitors;
 - (b) test strips for blood glucose monitors, visual reading and urine test strips;
 - (c) insulin;
 - (d) injection aids;
 - (e) syringes;
 - (f) insulin pumps and accessories to the pumps;
 - (g) insulin infusion devices;
 - (h) prescriptive oral agents for controlling blood sugar levels;
 - (i) foot care appliances for prevention of complications associated with diabetes; and
 - (j) glucagon emergency kits.
2. If you or your dependent incurs Expense for diabetes outpatient self-management training and education, including medical nutrition therapy, benefits will be paid in the same manner and subject to the same conditions and limitations as any other covered service.

Exceptions

We will not pay for:

- (a) any Expense not recommended or prescribed by a Physician or other licensed health care provider;
- (b) any Expense which is paid under any other provision of the Plan; or

- (c) anything excluded under the General Exclusions or Limitations; except that any podiatric appliance covered under item 1 (i) above will not be excluded.

Body Organ Transplant Benefits

Please note: Organ transplants require pre-authorization. Please contact the Trust office for additional information.

If you or your dependent incurs Expense for transplant surgery, we will pay Expenses incurred by a Recipient in the same manner as any other Sickness. The following are included as Covered Services:

- (a) the use of temporary mechanical equipment, pending the acquisition of “matched” human organ(s);
- (b) multiple transplant(s) during one operative session;
- (c) replacement(s) or subsequent transplant(s); and
- (d) follow-up Expenses for covered services (including immunosuppressant therapy) up to the follow-up limit shown in the schedule.

Exceptions

We will not pay for:

- (a) any Expenses when approved alternative remedies are available; or
- (b) any animal organ or mechanical:
 - (1) equipment;
 - (2) device; or
 - (3) organ(s);except as provided under this section.
- (c) donor expenses

Medical Emergency

If you or your dependent requires Emergency Services for a Medical Emergency, we will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other covered service.

Contraceptives Benefits

Definition

Contraceptive Drugs and/or Devices means drugs or devices that prevent unwanted pregnancy including, but not limited to:

- (a) oral contraceptives;
- (b) IUD's;
- (c) contraceptive implants; or
- (d) any similar drug, device or method.

Benefits

If an Insured Person receives Contraceptive Drugs and/or Devices, including any services associated with the use of such drug or device, we will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service. Removal of such devices will only be covered if medically indicated.

Conditions

The Contraceptive Drug and/or Device:

- (a) requires a Physician's written prescription;
- (b) must be approved by the United States Food and Drug Administration for use as a contraceptive; and
- (c) removal of an IUD is subject to medical necessity review.

Exception

Any exclusion for birth control drugs or devices will not apply.

Restoration of Maximum

After at least \$1,000 of payable benefits has been paid for Expenses incurred by any one person, \$1,000 will automatically be added to the balance of the maximum the first of each Calendar Year until the original maximum is reinstated. Furthermore, at any time after benefits have been paid under this provision, the maximum may be restored to its entirety by providing evidence of good health acceptable to us.

PREFERRED PRESCRIPTION DRUG PROVIDER OPTION

For You and Your Dependents

NOTE: If you or your dependent are Medicare eligible and are enrolled in a Medicare Part D prescription drug plan, outpatient prescription drug benefits will not be provided under this Plan.

When you or your dependents require Covered Drugs, the Insured Person may choose any pharmacist they wish. However, if the Insured Person uses the services of a Preferred Prescription Drug Provider, benefits may be subject to a more favorable Co-payment or Percentage Payable (as shown below). Regardless of the provider chosen, benefits will be subject to all other terms, conditions and limitations of the Plan.

We will publish an updated list of members periodically. For the current list of members, contact the Plan Administrator. We will also provide the Insured Person with a prescription drug card.

We do not supervise, control or guarantee the services of any Preferred Prescription Drug Provider or Other Provider.

Payment of Claims for Preferred Prescription Drug Providers

Prescription Drug Retail Claim Form

The Insured Person pays the total Expense at the pharmacy when using the Prescription Drug Program Retail Claim Form. Reimbursement will be made for the total Expense less the Co-payment for each prescription or refill. The claim form can be used:

- (a) prior to the effective date of the Prescription Drug retail program;
- (b) before receiving the Prescription Drug card if the Insured Person became eligible after the effective date of the Prescription Drug retail program; or
- (c) before receiving a replacement Prescription Drug card if the Insured Person has lost the card.

Use the claim form when purchasing a **30-day or less supply** of Covered Drugs. If purchasing more than a 30-day supply on the same day, any Expense exceeding the supply limit will not be covered. Present the claim form to the Preferred Prescription Drug Provider when purchasing Prescription Drugs. Follow the instructions on the form.

Prescription refills will be covered when no more than 25% of the days supply remains based on the Physician's written order.

Prescription Drug Retail Program (Card)

The Insured Person pays only the Co-payment for each prescription or refill when using the Prescription Drug retail program. Use the Prescription Drug card when purchasing a **30-day or less supply** of Covered Drugs. If purchasing more than a 30-day supply on the same day, any Expense exceeding the supply limit will not be covered. Present the card to the Preferred Prescription Drug Provider each time a prescription is purchased.

If the Physician is prescribing Maintenance Drugs, have the Physician write two prescriptions:

- (a) the first for the Insured Person's immediate needs; and
- (b) the second for the Insured Person to submit to the Mail Order Program.

Prescription refills will be covered when no more than 25% of the days supply remains based on the Physician's written order.

Exclusion

We will not pay Prescription Drug benefits for Drugs that have been determined under the internal standards of the Food and Drug Administration to be "less-than-effective" in accordance with the Drug Efficacy Study Implementation (DESI) or where the same Prescription Drug item is also available over-the-counter.

Please refer to the General Exclusions and Limitations found later on in this booklet for additional exclusions applicable to the Prescription Drug Plan.

Coordination of Benefits

This Prescription Drug Plan does not coordinate benefits with any other insurance coverage.

Co-Payments

Your Co-payments depend on whether the prescription is for a Generic Drug or Brand Name Drug. The Co-payments are available:

- (a) 20% for Generic Drugs;
- (b) 25% for Brand Name Drugs when Generic Drugs are not available; and
- (c) 50% for Brand Name Drugs when Generic Drugs are available.

MAIL ORDER PRESCRIPTION DRUG BENEFIT

For You and Your Dependents

NOTE: If you or your dependent are Medicare eligible and are enrolled in a Medicare Part D prescription drug plan, outpatient prescription drug benefits will not be provided under this Plan.

The mail order Prescription Drug program is specifically designed to help protect you and your family's good health. The program saves money and encourages you to ask your Physician to prescribe Generic Drugs whenever possible.

The mail order program is administered by Medco by Mail and is designed for Maintenance Drugs for ongoing or chronic conditions. Prescriptions for up to a 90-day supply may be filled by mail through this program. The group number for the Medco Health Plan is PAINTER.

This program is completely separate from the major medical benefits and does not coordinate benefits with any other insurance coverage. You do not have to satisfy the annual deductible for the mail order Prescription Drug benefits. Your Co-payment depends on whether the prescription is for a Generic Drug or Brand Name Drug. The Co-payments are:

- (a) 20% for Generic Drugs;
- (b) 25% for Brand Name Drugs when Generic Drugs are not available; and
- (c) 50% for Brand Name Drugs when Generic Drugs are available.

You can choose to use this mail order benefit, or you may purchase your Drugs at your regular pharmacy, receiving reimbursement under the regular major medical benefit provisions.

How to Use the Mail Order Program

To use the mail order program for the first time, complete the patient profile questionnaire for each family member who will use this program. The questionnaire asks for information about your medical history, blood type, allergies and any other Drugs you are taking (prescription and over-the-counter). Medco by Mail keeps this information and checks it every time you send a prescription. You may update your profile as you like by including any health condition changes with your prescription.

Follow these steps:

- (a) obtain an envelope from the Administrative Office or your local Union. Complete the information requested on the envelope. Be sure to include all required information, including your Physician's name. Medco by Mail automatically fills your prescriptions with a Generic Drug whenever possible;
- (b) if you are getting a new prescription filled, have your Physician prescribe up to a 90-day supply of the Maintenance Drug with the appropriate number of refills. If your Physician specifies a Brand Name Drug and writes "Dispense as Written" (DAW) on the prescription, the pharmacist will fill your prescription with the Brand Name Drug rather than filling it with a Generic Drug. However, the pharmacist may call your Physician to request approval of filling your prescription with a Generic Drug;

- (c) if you are requesting a refill, you should request your refill at least two weeks before your prescription runs out. With each prescription, Medco by Mail sends a postage-paid envelope (for your future use) and a notice showing how many refills you have left. Be sure to contact your Physician when you request your last refill from Medco by Mail;
- (d) send your prescription (and questionnaire if it is your first order or request for a refill) and the appropriate Co-payment in the postage-paid envelope to Medco by Mail. You can pay by check, money order, MasterCard, Visa or Discover card. If you use a credit card, include the card number and expiration date. **DO NOT SEND CASH**; and
- (e) within two weeks after ordering, your prescription will arrive at your home by United Parcel Service (UPS) or U.S. Mail.

You can call Medco by Mail directly for information and to order refills. The toll-free number is: 1-800-711-0917. You can call seven days a week, 24 hours a day. Emergency pharmacy consultation is also available seven days a week, 24 hours a day.

The following is a list of Drugs covered by the mail order program:

- (a) federal or state Legend Drugs;
- (b) injectable insulin, including insulin syringe and related supplies;
- (c) injectables, other than insulin; and
- (d) Retin-A (for acne only).

Exclusions

The following are excluded under the mail order program:

- (a) syringes, other than for use with insulin;
- (b) fertility Drugs;
- (c) obesity Drugs;
- (d) over-the-counter items;
- (e) Rogaine;
- (f) prescription vitamins; and
- (g) any exclusion or limitation included in the General Exclusions and Limitations found later in this booklet.

FAMILY AND MEDICAL LEAVE

as Federally Mandated

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act), your insurance may be continued on the same basis as if you were an actively-at-work employee for up to 12 weeks during the 12-month period, as defined by your employer, for any of the following reasons:

- (a) to care for your child after the birth or placement of a child with you for adoption or foster care, so long as such leave is completed within 12 months after the birth or placement of the child;
- (b) to care for your spouse, child, foster child, adopted child, stepchild or parent who has a Serious Health Condition; or
- (c) for your own Serious Health Condition.

In the event you or your spouse are both insured as employees of the Plan, the continued coverage under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a Serious Health Condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions

1. If, on the day your insurance is to begin, you are already on an FMLA leave of absence, you will be considered actively-at-work. Insurance for you and any eligible dependents will begin in accordance with the terms of the Plan. However, if your leave of absence is due to your own or any eligible dependent's Serious Health Condition, benefits for that condition will not be payable to the extent benefits are payable under any Prior Group Plan.
2. You are eligible to continue insurance under FMLA if:
 - (a) You have worked for your employer for at least one year;
 - (b) You have worked at least 1,250 hours over the previous 12 months;
 - (c) Your employer employs at least 50 employees within 75 miles from your worksite; and
 - (d) You continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.
3. In the event you choose not to pay any required premium during your leave, your insurance coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not insured. You and any insured dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
4. You and your dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

5. If requested by us, you or your employer must submit proof acceptable to us that your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
 - (a) the day you return to work;
 - (b) the day you notify your employer that you are not returning to work;
 - (c) the day your coverage would otherwise end under the Plan; or
 - (d) the day coverage has been continued for 12 weeks.

Definitions

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Prior Group Plan means the group plan providing similar benefits (whether insured or self-insured, including HMOs and other prepayment plans provided by the Plan) in effect immediately prior to the effective date of this Plan.

Serious Health Condition is defined as stated in the FMLA.

Important Notice

Contact your employer for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS

as Federally Mandated

Continuation of Group Health Insurance

1. **For You and Your Eligible Dependents.** If Health Insurance ends because of your Service in the Uniformed Services, you may elect to continue such Health Insurance, if required by USERRA until the earlier of:
 - (a) the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
 - (b) 24 consecutive months after insurance ended.
2. To continue coverage, you or your dependent must pay the required premium (including your former employer's share and any retroactive premium), unless your Service in the Uniformed Service is for fewer than 31 days, in which event you must pay your share, if any, of the premium. The Plan Administrator will inform you or your dependent of procedures to pay premiums.
3. **End of Continuation.** An Insured Person's continued Health Insurance will end at midnight on the earliest of:
 - (a) the day your former employer ceases to provide any group plan to any employee;
 - (b) the day premium is due and unpaid;
 - (c) the day an Insured Person again becomes covered under the Plan;
 - (d) the day Health Insurance has been continued for the period of time provided in part 1 (a) or (b) above (or any longer period provided in the Plan); or
 - (e) the day the master Plan terminates.

Any Health Insurance for an eligible dependent will also end as provided in the Dependents Eligibility provision of the Plan.
4. **Other Continuation Provisions.** In the event Health Insurance is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Reemployment (following Service in the Uniformed Services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any then existing health coverage provided by your employer.

Other Benefits

Your employer's leave of absence policy will determine your right to participate in any group life or other insurance.

After reemployment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility or costs.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

Definitions

Health Insurance means Hospital, surgical, medical, dental, vision, or Prescription Drug insurance provided under the Plan. Health Insurance is subject to change as a result of open enrollments or plan modifications.

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed Service means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

COORDINATION OF BENEFITS (COB)

If the Claimant is covered by another Plan or Plans, the benefits under the Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

1. The primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The secondary Plan (which is the Plan that pays benefits after the primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary Plan will not exceed 100% of total Covered Expense exclusive of Copayments, deductibles and other cost-sharing arrangements.

The Order of Benefit Determination paragraph below explains the order in which Plans must pay. In the event the Insured Person is covered by Medicare, then the Order of Benefit Determination for Medicare applies.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is \$50 or less, but if:

- (a) additional Expense is incurred during the Claim Period; and
- (b) the total Covered Expense exceeds \$50;

then this COB provision will apply to the total amount of the claim.

Order of Benefit Determination

When another Plan **does not** have a COB provision, that Plan must determine benefits first.

When another Plan **does** have a COB provision, the first of the following rules which applies govern:

- (a) if a Plan covers the Claimant as an employee, member or nondependent, then that Plan will pay its benefits first;
- (b) if the Claimant is a dependent child whose parents **are not** divorced or separated then the Plan of the parent whose birthday anniversary is earlier in the Calendar Year will pay first; except:
 - (1) if both parents' birthdays are on the same day, rule (d) below will apply; or
 - (2) if another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits;
- (c) if the Claimant is a dependent child whose parents **are** divorced or separated, then the following rules apply:
 - (1) a Plan which covers a child as a dependent of a parent who by court decree must provide health coverage will pay first; and
 - (2) when there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - a. when the parent who has custody of the child **has not** remarried, that parent's Plan will pay first; or

- b. when the parent who has custody of the child **has** remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second and by the Plan of the parent without custody third; and
- (d) if none of the above rules apply, the Plan which has covered the Claimant for the longer period of time will pay its benefits first, except when:
 - (1) one Plan covers the Claimant as a laid-off or retired employee (or a dependent of such an employee); and
 - (2) the other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);

then the Plan which covers the Claimant as **other than** a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

Order of Benefit Determination for Medicare

1. For You. We have primary responsibility for your claims if:

- (a) You are insured under the Plan because of your current active employment status with an ADEA Employer, and you are eligible for Medicare Benefits because of age; or
- (b) the Plan is part of a Large Group Plan, and you are insured under the Plan because of your current active employment status, and you are eligible for Medicare Benefits because of disability.

We have secondary responsibility for your claims if you are eligible for Medicare Benefits and the above conditions do not apply.

2. For Your Dependent. We have primary responsibility for your dependent's claims if:

- (a) You are insured under the Plan because of your current active employment status with an ADEA Employer, and your dependent spouse is eligible for Medicare because of age; or
- (b) the Plan is part of a Large Group Plan, and you are insured under the Plan because of your current active employment status, and your dependent is eligible for Medicare Benefits because of disability.

We have secondary responsibility for your dependent's claims if your dependent is eligible for Medicare Benefits and the above conditions do not apply.

3. Exception for End Stage Renal Disease. If Medicare does not already have primary responsibility when you or your dependent becomes eligible for Medicare Benefits because of end stage renal disease:

- (a) We have primary responsibility for your or your dependent's claims for up to 30 months beginning with the month in which you or your dependent is first eligible for Medicare Benefits because of end stage renal disease; and
- (b) We have secondary responsibility after the end of this 30-month period.

Important Information About Medicare

Medicare may affect Plan benefits; therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before your or your spouse's 65th birthday. A penalty may be imposed should you delay your enrollment with Medicare and your premium is increased when you do elect your Medicare coverage.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. This includes charges incurred in Veterans Affairs facilities.

Credit Savings

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the Claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

How COB Affects Benefit Limits

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

Automobile Insurance

When medical payments are available under a third party's vehicle insurance or Personal Injury Protection (PIP) the Plan shall pay excess benefits only.

Right To Collect and Release Needed Information

In order to receive benefits, the Claimant must give the insurer any information which is needed to coordinate benefits. With the Claimant's consent, the insurer may release to or collect from any person or organization any needed information about the Claimant.

Facility of Payment

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

Right of Recovery

If this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

- (a) the Claimant;
- (b) any person to whom the payment was made; or
- (c) any insurance company, service plan or any other organization which should have made payment.

NOTE: If a Claimant is covered under more than one Plan, it is recommended that the claim be submitted to all Plans at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

Definitions

ADEA Employer means an employer which:

- (a) is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
- (b) has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding Calendar Year.

Age 65 (as used in this provision) means the age attained at 12:01 a.m. on the first day of the month in which the Insured Person's 65th birthday occurs.

Claimant means the Insured Person for whom the claim is made.

Claim Period means part or all of a Calendar Year during which the Claimant is insured under the Plan.

A **Covered Expense** means the Usual and Customary Charge for any Medically Necessary health care service or supply which is covered at least in part by any of the Plans involved during a Claim Period. Where a Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of the service or supply during a Claim Period will also be considered a Covered Expense. The difference in cost of a private Hospital room and the cost of a semiprivate room is not considered a Covered Expense unless the Claimant's stay in a private room is considered Medically Necessary by at least one of the Plans involved.

Large Group Plan means a Plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous Calendar Year.

Medicare Benefits means benefits for services and supplies which the Insured Person receives or is eligible for under Medicare.

Plan means any of the following coverages (including Plan coverage) which provide benefits payments or services to an Insured Person for Hospital, medical, surgical, dental Prescription Drug or vision care:

- (a) group or blanket insurance (except student accident insurance);
- (b) group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
- (c) coverage under a labor-management trust Plan, a Union welfare Plan, an employer organization Plan or an employee benefits Plan;
- (d) coverage under government programs, other than Medicaid, and any other coverage required or provided by law;
- (e) other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type Hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds \$200 a day.

THIRD PARTY REIMBURSEMENT AND/ OR SUBROGATION

This provision applies if you or your dependent is injured or sick as a result of the act or omission of a Third Party.

Definitions

For the purposes of this provision, the following terms have the following meanings:

Reimbursement Rights means our right to be reimbursed if:

- (a) We pay Plan benefits for you or your dependent because of an Injury or Sickness caused by a Third Party's act or omission; and
- (b) You, your dependent or the legal representative recovers an amount from the Third Party, the Third Party's insurer, an uninsured motorist insurer or anyone else by reason of the Third Party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. We are entitled to be paid out of any recovery, up to the amount of Plan benefits we pay.

Subrogation Rights, as used in this provision, means our right to enforce our recovery of any Plan benefits paid for you or your dependent because of an Injury or Sickness caused by a Third Party's act or omission. We are entitled to be paid out of any recovery, up to the amount of Plan benefits we pay.

Third Party means another person or organization.

Reimbursement Rights and Subrogation Rights

If you or your dependent has an Injury or Sickness caused by a Third Party's act of omission:

1. We will pay Plan benefits for that Injury or Sickness subject to our Reimbursement Rights and Subrogation Rights and on condition that you or your dependent (or the legal representative of you or your dependent):
 - (a) will not take any action which would prejudice our Reimbursement Rights or Subrogation Rights; and
 - (b) will cooperate in doing what is reasonably necessary to assist us in enforcing our Reimbursement Rights or Subrogation Rights.
2. Our Reimbursement or Subrogation Rights will not be reduced because:
 - (a) the recovery does not fully compensate you or your dependent for all losses sustained or alleged; or
 - (b) the recovery is not described as being related to medical costs or loss of income.
3. We may enforce our Reimbursement Rights or Subrogation Rights by filing a lien with the Third Party, the Third Party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.
4. The amount of our Reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless we agree otherwise in writing.

5. We may elect to charge any reimbursement due us under this provision against any further benefit payments for you or your dependent under this Plan. This will not reduce our right to be paid out of any recovery up to the amount of Plan benefits not yet reimbursed.

HEALTH CONTINUATION/CONVERSION

If an Insured Person is eligible for continuation of group health insurance when such insurance would otherwise end, the Insured Person may obtain conversion coverage under any health conversion provision in the Plan only if the Insured Person:

- (a) has elected the continuation option; and
- (b) has remained covered during the fall period of continuation.

If the Insured Person is eligible for more than one continuation period under the Plan, the Insured Person must remain insured for the longest period.

MEDICAL CONVERSION

For You and Your Dependents

Definitions

Health Insurance means Hospital, surgical or medical insurance provided under the Plan on an Expense-incurred basis.

Conversion Coverage means individual or family Hospital, surgical and medical insurance, then available, issued without evidence of good health.

NOTE: Conversion Coverage may not provide the same insurance benefits you or your dependent had while insured under the Plan. Consequently, Expenses covered under the Plan may not be covered by the Conversion Coverage or may be covered at a different level. You may contact the Plan Administrator at any time for a description of the conversion benefits then available. Conversion Benefits are subject to change.

Available To You

Conversion Coverage is available to you if your Health Insurance ends because your eligibility ends.

Available To Dependents

Conversion Coverage is available to your dependents if their Health Insurance ends because:

- (a) your Health Insurance ends;
- (b) you die or your marriage is ended by divorce or annulment; or
- (c) a child reaches the limiting age in the Plan.

Exceptions to Availability of Conversion Coverage

Conversion Coverage is not available to you or your dependents when:

- (a) the Plan ends or your employer withdraws from the group;
- (b) you or your dependent have similar individual or group coverage;

- (c) you or your dependent are eligible for or have Medicare coverage;
- (d) you have been insured under the Plan (including any similar group coverage the Plan replaces) less than three months before your or your dependent's Health Insurance ends;
or
- (e) you or your dependent reside in a state that does not require us to provide you with conversion.

Please contact us at 1-800-566-4455 for further information about the availability of conversion.

Option To Obtain Conversion Coverage

If a completed application and the first premium payment is sent to us within 31 days from when Health Insurance ends,* Conversion Coverage will be issued in accord with:

- (a) our rules; and
- (b) the conversion law in effect when application is made.

***NOTE:** Application must be made when Health Insurance ends; not when any Extended Benefits coverage ends.

Application may be made:

- (a) by you:
 - (1) for yourself; or
 - (2) for yourself and any dependent whose Health Insurance ends because your Health Insurance ends; or
 - (3) for any dependent who does not have the legal capacity to apply; or
- (b) by any dependent to whom Conversion Coverage is available.

Conditions

Conversion Coverage begins immediately after insurance under the Plan ends. Expense for which benefits are payable under the Plan will not be paid under the Conversion Coverage. Coverage for conditions which are excluded under the Plan may be excluded under the Conversion Coverage.

COBRA GROUP HEALTH INSURANCE CONTINUATION **(As Federally Mandated)**

ALL PARTICIPANTS

Under the circumstances described below, you, your lawful spouse and eligible dependents each have the independent right to elect to continue your Trust health coverage beyond the time coverage would ordinarily have ended pursuant to a Federal law known as COBRA. The Plan Administrator is responsible for administering COBRA continuation rights for the Trust. All communications must be made in writing, identifying the person or persons requesting coverage, and be sent to the Plan Administrator.

Qualifying Events

You (as the participating employee) have the right to elect continuation of your health coverage from the Trust if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment (other than due to gross misconduct.)

Your spouse has the right to choose continuation of coverage if he or she would otherwise lose eligibility for any of the following reasons:

- (a) The participating employee's termination of employment or reduction in hours of employment; (other than due to gross misconduct.)
- (b) Death of the participating employee;
- (c) Divorce or legal separation from the participating employee; or
- (d) The participating employee becoming entitled for Medicare.

A dependent child has the right to elect continuation of coverage if eligibility would otherwise be lost for any of the following reasons:

- (a) The participating employee's termination of employment or reduction in hours of employment; (other than due to gross misconduct.)
- (b) Death of the participating employee;
- (c) Divorce or legal separation from the participating employee;
- (d) The participating employee becoming entitled for Medicare; or
- (e) The child no longer qualifying as an eligible dependent under the Plan.

Your COBRA Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Trust Office of a loss of coverage resulting from a divorce, legal separation or a child losing dependent status. **If you or your eligible dependents have a loss of coverage because of these events, you must notify the Trust Office in writing at the address listed above within 60 days from the latest of: (a) the date of the qualifying event, (b) the date on which there is a loss of coverage; or (c) the date on which the qualified beneficiary is informed of his/her obligation to provide notice and the procedures for providing such notice. The notice must identify the Individual who has experienced the qualifying event, the eligible employee's name and the qualifying event which occurred.**

Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan.

Your employer is responsible for informing the Trust if your employment is terminated. The Trust's administrative office will determine when the Employee's hour bank falls below 120 hours. The Board of Trustees, though, reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA

Once the Trust Office has received proper notice that a qualifying event has occurred, it will notify you and each of your eligible family members, of your rights to elect continuation coverage. A written election must be made in writing within 60 days from the date coverage would otherwise end or 60 days from the date the notification is received from the Trust, if later. An election of COBRA coverage under the Trust by one family member covers all other eligible members of the same family, provided that such family members are specifically listed on the election form as completed by you or the Plan Administrator. Notice must be sent to the Trust's administrative office.

Failure to elect continuation within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

Available Coverage

The continuation coverage offered is the same as the Trust-paid coverage provided to the employees of your current employer, and the Employee's eligible dependents. COBRA does not include life insurance or short term disability coverage.

Adding New Dependents

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. If you elect COBRA, any new eligible dependents you acquire may be added in accord with the Dependent's Eligibility provisions of the Plan. To add such new dependent you must provide written notice to the Trust Office within 31 days of acquiring the new dependent. The written notice must identify the employee, the new dependent, the date the new dependent was acquired and be mailed to the Trust's administrative office. Only newborn dependents are entitled to extend their continuation coverage if a second qualifying event occurs as discussed below.

Continuous Coverage Required

Your coverage under COBRA must be continuous from the date your Trust coverage would have otherwise ended if COBRA was not elected. If you initially reject COBRA continuation coverage before the end of your 60-day election period, you may change your election to elect COBRA continuation coverage provided that you furnish a completed election form by the end of your original 60-day election period. However, your COBRA continuation coverage will begin on the date the completed Election Form is sent to the Trust Office, and not on the date of the qualifying event.

Cost

A qualified beneficiary must pay the entire cost of the continuation coverage. The Trust uses a composite rate which means that you pay the same monthly rate if you are covering one person or an entire family. The cost for the coverages available through the Trust is set annually. If you have

a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you. If you are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage will be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your disability.

Monthly Self-Payments Required

COBRA self-payments are due on the first of each month for that month's coverage and must be sent to the Trust Office at:

The Employee Painters' Trust
Health & Welfare Plan
104 S. Freya, Ste. 220
Spokane, Washington 99202
Phone (800) 566-4455

Coverage will be terminated if payment is not received by the Trust Office within 30 days of this due date. Checks that are received and do not clear the bank due to insufficient funds are considered non-payment. The only exception is that the self-payment for the period preceding the initial election of coverage may be made up to 45 days after the date of election. If your initial payment is not received or postmarked within 45 days of when you elected coverage, your right to continuation coverage will be lost.

Length of Continuation Coverage

Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours. For dependent qualifying events (death of employee, divorce or legal separation from employee, employee becoming Medicare entitled or a child no longer qualifying as a dependent under the Plan) continuation of coverage may last for up to 36 months following the initial 18-month qualifying event date. However, continuation coverage will end on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- (a) A required self-payment is not paid to the Trust's administrative office on a timely basis for the next monthly coverage period;
- (b) You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking continuation coverage);
- (c) You or your eligible dependent provide written notice that you wish to terminate your coverage;
- (d) You or your eligible dependent become entitled to Medicare benefits after the date of your COBRA election; or
- (e) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee.
- (f) The day the insured person again becomes eligible to be covered under the Trust.
- (g) The last day of your maximum COBRA coverage period ends (e.g. 18, 29 or 36 months, as applicable).

Length of Continuation Coverage - Disabled Participants

If you, your spouse or any dependent covered by the Trust is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage, the individuals who have previously been elected to receive COBRA coverage can receive an additional 11 months of continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Trust's administrative office in writing within 60 days of receipt of your Social Security Disability Determination and prior to the end of your initial 18-month period of continuation coverage. If the disabled individual is subsequently found to not be disabled, you must notify the Trust's administrative office in writing within 30 days of this determination.

Length of Continuation Coverage - Second Qualifying Event

Eligible dependents who are entitled to continuation coverage as the result of the employee's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs during the initial 18 months of continuation coverage. Possible second qualifying events are the employee's death, a divorce or legal separation from the employee, a child losing dependent status or the employee becoming entitled for Medicare during the initial 18 months of continuation coverage.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Trust's administrative office in writing within 60 days of the second qualifying event. Failure to give such timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the Plan. In no event will continuation of coverage extend beyond a total of 36 months.

Relationship Between COBRA and Medicare or Other Health Coverage

An individual's COBRA coverage will terminate if he/she becomes entitled to Medicare or other group health coverage after his/her COBRA election. However, if an Individual is entitled to Medicare or other group coverage at the time he/she elected COBRA, the individual can be eligible for both coverages.

If you have coverage under a Trust-sponsored Plan based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have received short-term disability benefits for less than six months. If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute. If you have other group health coverage, it will pay primary and the Trust's continuation coverage will be secondary.

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law: 1) you can lose the right to avoid having preexisting condition exclusions apply to you under a future group health plan if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you avoid such a gap; 2) you can lose the right to purchase guaranteed individual health coverage that does not impose a preexisting condition exclusion if you do not obtain a continuation coverage for the maximum time available to you; and 3) you should be aware that federal law gives you special

enrollment rights. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You may also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

In order to protect your family's rights, you should keep the Trust Office informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Trust Administrator.

Additional Information

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration or visit its website at www.dd.gov/esba.

EXTENSION OF BENEFITS

If you or your dependent is Totally Disabled by Injury or Sickness on the date eligibility ends, the Plan will extend continuation coverage for covered services as if eligibility had not ended, up to a maximum of twelve (12) consecutive months from the date active eligibility ends or, if earlier,

- (a) the date you or your dependent becomes covered under another group health care plan; or
- (b) the date the Total Disability ends.

Benefits payable are those in effect on the date eligibility ended.

This Extension of Benefits coverage period described above shall run concurrently with continuation coverage time periods available to you under COBRA (refer to COBRA GROUP HEALTH INSURANCE CONTINUATION found later on in this booklet for a description of COBRA continuation coverage.) Under this Extension of Benefits provision, and if you elect COBRA, the Trust Fund shall pay on your behalf the first twelve (12) months COBRA continuation premiums that are required to be paid for COBRA coverage. Premiums for COBRA coverage which continue after the expiration of the 12-month period must be paid by you or your dependent.

GENERAL EXCLUSIONS AND LIMITATIONS

These General Exclusions and Limitations do not apply to any Life Insurance Benefits provisions.

We do not pay under the **Health Insurance** provisions (including any Accidental Death and Dismemberment Benefits provision and Weekly Disability Benefits provision) for:

- (a) any Injury or Sickness which arises out of or in the course of any employment with any employer or for which the Insured Person is entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a worker's compensation carrier (but this exclusion does not apply to any Accidental Death and Dismemberment Benefits provision);
- (b) any Expense which is in excess of the usual and customary Global Charges;
- (c) any Expense or charge for services or supplies not Medically Necessary;
- (d) any Expense incurred after insurance ends (except as specifically provided under any extended benefits provisions in the Plan);
- (e) any Expense which is not the result of an Injury or Sickness as defined in the Definitions section of the Plan, except as otherwise specifically covered under the Plan*;
*This exclusion applies only to any Accidental Death and Dismemberment;
- (f) any loss, Expense or charge resulting from the Insured Person's participation in a riot or in the commission of a felony;
- (g) any Expense or charge which the Insured Person does not have to pay;
- (h) any treatment, service or supply unless it is shown as a covered service;
- (i) contact lenses, except as specifically provided;
- (j) eye refractions or the fitting or cost of visual aids or surgery to correct visual acuity;
- (k) the fitting or cost of hearing aids, except as specifically provided;
- (l) Alcohol and Drug Abuse, except as provided under the chemical dependency benefit;
- (m) Mental Sicknesses, except as provided under that section;
- (n) any Expense or charge for preventive shots, vaccinations and inoculations, except as specifically provided;
- (o) any Expense or charge for routine physical exams, checkups or premarital exams, except as specifically provided;
- (p) any Expense or charge for failure to appear for an appointment as scheduled, or for completion of claim form or for additional information as requested for claims processing;
- (q) any Expense or charge for medicines, vitamins or any other supplements not prescribed for an illness except as specifically provided;
- (r) any Expense or charge which is older than 12 months from the date of service from date received;
- (s) services and supplies which are for conditions related to autistic disease of childhood, milieu therapy, learning disabilities, developmental disability or for hospitalization for environmental change;

- (t) services or supplies by a provider who normally resides in your home or is related to you by blood or marriage;
- (u) Spinal Treatment, except as specifically provided under the Spinal Treatment benefit;
- (v) any Expense or charge for Custodial Care or Developmental Care;
- (w) any Expense which results from Reconstructive Surgery, except:
 - (1) for an Injury;
 - (2) for repair of defects which result from surgery; or
 - (3) for the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction;
- (x) any Expense which results from Cosmetic Surgery;
- (y) any loss, Expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by us, and present significant symptomatic medical problems) or any treatment of obesity (including surgery to treat morbid obesity);
- (z) any Expense or charge for orthopedic shoes, orthotics or other supportive devices for the feet, except as specifically provided in the Plan;
- (aa) any Expense or charge in connection with dental work, dental surgery or oral surgery (unless specifically provided or except as required by law), including:
 - (1) treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
 - (2) surgery or splinting to adjust dental occlusion;
- (ab) any Expense or charge for treatment of Jaw Joint Disorders (unless specifically provided);
- (ac) any loss, Expense or charge for sex transformations or any treatment related to sexual dysfunction;
- (ad) any loss, Expense or charge related to Mental Sicknesses which are classified as sexual deviations or disorders;
- (ae) any Expense or charge for the diagnosis or treatment of fertility or infertility or promotion of fertility including (but not limited to):
 - (1) fertility tests and procedures;
 - (2) reversal of surgical sterilization; and
 - (3) any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any treatment or method;
- (af) chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
- (ag) any Expense or charge for services or supplies which are not provided in accordance with generally accepted professional standards on a national basis;
- (ah) any Expense or charge for services or supplies which:
 - (1) are considered Experimental or Investigational Drugs, Devices, Treatments or Procedures; or
 - (2) result from or relate to the application of such Experimental or Investigational Drugs, Devices, Treatments or Procedures;

- (ai) any Expense or charge which is primarily for the Insured Person's education, training or development of skills needed to cope with an Injury or Sickness, unless specifically provided in the Plan;
- (aj) any Expense or charge which is primarily for the Insured Person's convenience or comfort or that of the Insured Person's family, caretaker, Physician or other medical provider;
- (ak) any Expense or charge for telephone calls to or from a Physician, Hospital or other medical provider;
- (al) any loss, Expense or charge which results from breast augmentation or reduction which is not associated with cancer of the breast;
- (am) any loss, Expense or charge which results from services from developmental disability. (When we, our medical staff or a qualified party or entity selected by us determine that a confinement or visit is mainly for developmental disability, some services such as Prescription Drugs, x-rays and lab tests may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration);
- (an) any Expense or charge for services or supplies which are provided or paid for by federal government or its agencies; except for:
 - (1) the Veterans Administration, when services are provided to a veteran for a disability which is non service-connected;
 - (2) a military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or
 - (3) a group health plan established by a government for its own civilian employees and their dependents;
- (ao) any loss, Expense or charge which results from an act of declared or undeclared war;
- (ap) any loss, Expense or charge:
 - (1) which is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
 - (2) for which any governmental body or its agencies are liable; or
- (aq) marriage or family counseling.

PAYMENT OF CLAIMS

Only claims incurred on or after the effective date of your insurance will be processed. In order for you to receive prompt payment for your claims, the procedures listed below should be followed as closely as possible.

1. Obtain a claim form from your local Union office or the Trust Office. If you utilize a Preferred Provider, you do not need to complete a claim form. You must present your I.D. card to the provider who will then submit the claim for you.
2. Complete your portion, part 1, by inserting all of the information requested and sign your name on the line specified.
3. For Physician's services, attach an itemized copy of your Physician's bill or have your Physician complete his portion of the claim form.
4. For Hospital services, attach an itemized copy of the Hospital bill which lists all services and supplies received.
5. For Prescription Drugs not obtained through the Retail Plan or Mail Order Prescription Drug program, be sure to attach itemized pharmacy receipts showing the name of the individual for whom the Drugs were prescribed, the prescription number, name of Drug prescribed and the name of the Physician prescribing the Drug.
6. For weekly disability benefits, you and your Physician must complete the form.
7. Dental Expenses incurred as a result of an accident should be submitted with complete accident details to the medical plan for payment.
8. You should then forward the completed claim form together with itemized bills to the Trust Office, at the following address:

The Employee Painters' Trust
c/o Zenith Administrators, Inc.
P.O. Box 2523
Spokane, Washington 99220
Phone: 1-509-534-0265 or 1-800-566-4455
Fax: 1-509-534-5910

Your claim and all bills connected with it must be submitted to the Trust Office within 90 days following the date Expenses are incurred, or as soon as reasonably possible, but not later than 12 months after loss occurs, unless the claimant is not legally capable.

9. Payment can be handled in two ways:
 - (a) You may assign payment of benefits by signing the authorization on the claim form or by filling out one of the provider's own assignment forms. If you do assign your benefits, the payment will be sent directly to the provider of service (payments to Preferred Providers are automatically paid to the provider); or
 - (b) You may pay the bill directly, in which case the benefit checks will be made payable to you.

Appeal Procedure for Denial of Experimental and Investigational Services

Based upon information submitted, if we deny a request for benefits or refuse to approve a request to preauthorize services because of an experimental or investigational exclusion or limitation, you may appeal any denial directly to us within 60 days after receiving the denial notification. We will notify you in writing of a final determination within 14 working days of receipt of the fully documented appeal. The review period will extend beyond 14 working days only with the informed written consent of the Insured Person.

Appeal Rights

(Medical Benefits) (as Federally Mandated)

Definitions

Capitalized terms have the same meaning as shown in the Plan and the Precertification and Claim Review Procedures provision.

For the purposes of this Appeal Rights provision, the terms **you, your, yours** shall include your authorized representative.

Opportunity To Request An Appeal

You shall have a reasonable opportunity to appeal the Plan's precertification or claim review decisions in accordance with this Appeal Rights provision. As part of the appeal, there will be a full and fair review of the precertification and/or claim review decisions.

The request for an appeal can be written, electronically or orally submitted and should include any additional information you believe may have been omitted from the Plan's review or that should be considered by the Plan.

The Plan will establish and maintain procedures for hearing, researching, recoding and resolving any appeal. The notification you receive regarding the Plan's precertification or claim review decision will include instructions on how and where to submit an appeal.

You will have no later than 180 days from your receipt of notification of the Plan's precertification or claim review decision to submit a request for an appeal.

The request for an appeal should include:

- (a) the name of the patient;
- (b) the name of the person filing the appeal if different from the patient;
- (c) the policy number;
- (d) the member number;
- (e) the nature of the appeal; and
- (f) names of all individuals, facilities and/or services involved with the appeal.

By requesting an appeal, you have authorized the Plan, or anyone designated by the Plan, to review any and all records (including, but not limited to, your medical records) which the Plan determines may be relevant to your appeal.

Response To Appeals

Once the Plan receives your request for an appeal, the Plan will respond no later than:

- (a) 72 hours for Claims Involving Urgent Care;
- (b) 30 days for claims and services for benefits requiring precertification (excluding Claims Involving Urgent Care); and
- (c) 60 days for claims and services for benefits not requiring precertification.

When the Plan makes their determination, you will be provided with:

- (a) information regarding its decision; and
- (b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

Please refer to the Precertification and Claim Review Procedures provision.

Claim Review and Appeal Procedures

**(Accidental Death & Dismemberment and Weekly Disability Benefits)
(As Federally Mandated)**

Definitions

Capitalized terms have the same meaning as shown in the Plan.

For the purposes of this provision the following term has the following meaning:

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon the Insured Person's ineligibility for insurance under the Plan.

Claim Review Procedures

Once the Plan receives information necessary to evaluate the claim, the Plan will make a decision within the time periods set forth below. Please refer to the Payment of Claims provision of the Plan.

In the event an extension is necessary due to matters beyond the Plan's control, the Plan will notify the person submitting the claim of the extension and the circumstances requiring the extension. Extensions are limited as set forth below.

If an extension is necessary due to failure to submit complete information, the Plan will notify the person submitting the claim of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for the Plan to continue processing the claim, the missing information must be provided to the Plan within the time periods set forth below.

For accidental death & dismemberment, the Plan may contact the person submitting the claim at any time for additional details about the processing of the claim.

For weekly disability, you may contact the Plan at any time for additional details about the processing of the claim.

Accidental Death & Dismemberment Claim Review Decisions

- (a) Initial review: The Plan will notify the person submitting the claim of its claim decision within 45 days after the Plan's receipt of the claim, unless additional information is requested as set forth below;
- (b) Extension period: 30 days; and
- (c) Maximum number of extensions: two.

If additional information is needed, the Plan will notify the person submitting the claim within 30 days of the Plan's receipt of the claim. Once the Plan's request for additional information is received, the person submitting the claim will have 45 days to submit the additional information to the Plan. The Plan will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond its control) to process the claim. If the Plan does not receive the additional information within the specified time period, the Plan will make their determination based on the available information.

Disability Claim Review Decisions

- (a) Initial review: The Plan will notify you of its claim decision within 45 days after the Plan's receipt of your claim, unless additional information is requested as set forth below;
- (b) Extension period: 30 days; and
- (c) Maximum number of extensions: two.

If additional information is needed, the Plan will notify you within 30 days of the Plan's receipt of the claim. Once you receive the Plan's request for additional information, you will have 45 days to submit the additional information to the Plan. The Plan will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond its control) to process the claim. If the Plan does not receive the additional information within the specified time period, the Plan will make their determination based on the available information.

Accidental Death & Dismemberment Claim Denials

If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic notice of the denial which will include:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provisions on which the denial is based;
- (c) if applicable, a description of any additional material or information necessary to complete the claim and the reason the Plan needs the material or information;
- (d) a description of the appeal procedures; including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
- (e) any other information which may be required under state or federal laws and regulations.

Disability Claim Denials

If a claim is denied or partially denied, you will receive a written or electronic notice of the denial which will include:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provisions on which the denial is based;
- (c) if applicable, a description of any additional material or information necessary to complete the claim and the reason the Plan needs the material or information;
- (d) a description of the appeal procedures; including your right to request an appeal within 180 days and your right to bring a civil action following the appeal process; and
- (e) any other information which may be required under state or federal laws and regulations.

Additionally, if the Plan used an internal rule, guideline, protocol or other similar criterion in making an Adverse Benefit Determination, you will receive a statement of your right to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion.

Furthermore, if the Plan makes an Adverse Benefit Determination based upon a medical necessity or experimental treatment or a similar exclusion or limitation, the Plan will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to you upon request and free of charge.

For Accidental Death & Dismemberment, The Opportunity To Request An Appeal

The person submitting the claim may appeal the Plan's claim review decision in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, the Plan will perform a full and fair review of the decision.

The request for an appeal can be written, electronically or orally submitted to the Plan and should include any additional information that the person submitting the claim believes may have been omitted from the Plan's review that should be considered by the Plan.

The request for an appeal should include:

- (a) the name of the person for whom the claim has been submitted;
- (b) the name of the person filing the appeal;
- (c) the policy number; and
- (d) the nature of the appeal.

The Plan will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification of the Plan's claim review decision will include instructions on how and where to submit an appeal.

The person submitting the claim will:

- (a) have 60 days from receipt of notification to submit a request for an appeal;
- (b) be provided the opportunity to submit written comments, documents, records and other information relating to the claim; and

- (c) be provided, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim.

In reviewing the appeal the Plan will consider all comments, documents, records and other information submitted by the person submitting the claim relating to the claim, without regard to whether such information was submitted or considered in the claim decision.

Request for an appeal authorizes the Plan, or anyone designated by the Plan, to review records relevant to the claim.

For Accidental Death & Dismemberment, the Plan's Response To An Appeal

Once the Plan receives a request for an appeal, the Plan will respond within 60 days, unless additional information is requested. If additional information is requested, the following extensions apply:

- (a) extension period: 60 days; and
- (b) maximum number of extensions: one.

When the Plan makes their decision, the person submitting the claim will be provided with:

- (a) information regarding the Plan's decision; and
- (b) information regarding other internal or external appeal or dispute resolution alternatives, if available, including any required state mandated appeal rights.

Appeal Rights for Weekly Disability Opportunity To Request An Appeal

You may appeal the Plan's claim review decision in accordance with this Appeal Rights provision. As part of the appeal, the Plan will perform a full and fair review of the claim review decision.

The request for an appeal can be written, electronically or orally submitted to the Plan and should include any additional information you believe may have been omitted from the Plan's review or that should be considered by the Plan.

The Plan will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification you receive regarding the Plan's claim review decision will include instructions on how and where to submit an appeal.

You will have 180 days from your receipt of notification of the Plan's claim review decision to submit a request for an appeal.

The request for an appeal should include:

- (a) the name of the employee;
- (b) the name of the person filing the appeal if different from the employee;
- (c) the policy number; and
- (d) the nature of the appeal.

By requesting an appeal, you have authorized the Plan, or anyone designated by the Plan, to review your records.

Our Response To An Appeal

Once the Plan receives your request for an appeal, the Plan will respond no later than 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

- (a) extension period: 45 days;
- (b) maximum number of extensions: one.

The Plan will have a total of 90 days to process the appeal.

When the Plan makes their determination, you will be provided with:

- (a) information regarding its decision; and
- (b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

Precertification And Claim Review Procedures **(Medical Benefits)(as Federally Mandated)**

Definitions

Capitalized terms have the same meaning as shown in the Plan. For the purposes of this provision:

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, (in whole or in part), for a benefit, including, without limitation, any such denial, reduction, termination of, or failure to provide or make payment that is based upon:

- (a) the Insured Person's ineligibility for insurance under the Plan;
- (b) the Plan's determination that the treatment or service is not a Covered Service under the Plan;
- (c) a utilization review determination;
- (d) the Plan's determination that the treatment or service is considered an Experimental or Investigational Drug or Treatment; or
- (e) the Plan's determination that the treatment is not Medically Necessary.

Additionally, if the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a given number of treatments, any reduction or termination of such course of treatment by the Plan (other than by plan amendment or termination) before the end of such period of time or number of treatments is an Adverse Benefit Determination.

Claim or Request Involving Urgent Care means any claim or request for a benefit for medical care or treatment with respect to which the application of time periods for making nonurgent care determinations:

- (a) could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
- (b) in the opinion of a Physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without

the care or treatment that is the subject of the claim. Additionally, if a Physician with knowledge of the Insured Person's medical condition determines that a claim is a Claim or Request Involving Urgent Care, the claim shall automatically be treated as a Claim or Request Involving Urgent Care for the purposes of this provision.

Day(s) means calendar day(s).

For the purposes of these Precertification and Claim Review Procedures, the terms **you, your, yours** shall include the employee, dependent or your authorized representative.

Precertification and Claim Review Procedures

Once the Plan receives information necessary to evaluate the precertification request or evaluate the claim, the Plan will make a decision within the time periods set forth below. Please refer to the Utilization Management Provisions, if any; and the Payment of Claims provisions of the Plan.

In the event an extension is necessary due to matters beyond the Plan's control, the Plan will notify you of the extension and the circumstances requiring the extension. Except where you voluntarily agree to provide the Plan with additional time, extensions are limited as set forth below.

If an extension is necessary due to your failure to submit complete information, the Plan will notify you of the additional information required. Such notice of incomplete information will be sent within the time periods set forth.

In order for the Plan to continue processing your precertification request or claim, the missing information must be provided to the Plan within the time periods set forth below.

You may contact the Plan at any time for additional details about the processing of the precertification request or claim.

Claims or Requests Involving Urgent Care

Initial review: 72 hours, unless additional information is requested as set forth below.

If additional information is needed, the Plan will notify you within 24 hours of the Plan's receipt of the request. Once you receive the Plan's request for additional information, you will be given no less than 48 hours to submit the additional information to the Plan. The Plan will make their determination within 48 hours of its receipt of the additional information. If the Plan does not receive the additional information within the specified time period, the Plan will make their determination based upon the available information.

Claims or Requests For Benefits Requiring Precertification (excluding Claims or Requests Involving Urgent Care)

- (a) Initial review: 15 days unless additional information is requested as set forth below;
- (b) Extension Period: 15 days; and
- (c) Maximum number of extensions: one.

If additional information is needed, the Plan will notify you within five days of its receipt of the request. Once you receive the Plan's request for additional information, you will be given no less than 45 days to submit the additional information to the Plan. The Plan will make their determination within 15 days of its receipt of the additional information. If the Plan does not receive

the additional information within the specified time period, the Plan will make their determination based upon the available information.

Claims or Requests For Benefits Not Requiring Precertification

- (a) Initial review: 30 days;
- (b) Extension period: 15 days; and
- (c) Maximum number of extensions: one.

If additional information is needed, the Plan will notify you within 30 days of its receipt of the request. Once you receive the Plan's request for additional information, you will be given no less than 45 days to submit the additional information to the Plan. The Plan will make their determination within 15 days of its receipt of the additional information. If the Plan does not receive the additional information within the specified time period, the Plan will make their determination based upon the available information.

Claims or Requests for Benefits Involving Concurrent Care

The Plan will notify you of an Adverse Benefit Determination regarding a previously-approved ongoing course of treatment or number of treatments sufficiently in advance to allow you to appeal the Adverse Benefits Determination and obtain a determination of your appeal before such ongoing treatment is terminated or reduced. (Please refer to the Appeal Rights provision for additional information.)

If you request to extend the course of treatment beyond the period of time or number of treatments that were originally approved by the Plan, and such request is a Claim Involving Urgent Care, the Plan will notify you of their determination within 24 hours of its receipt of your request, provided that the Plan receives your request for extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Plan does not receive your request within the 24 hour period, the Plan will treat your request as described in the section entitled "Claims Involving Urgent Care."

If you request to extend the course of treatment beyond the period of time or number of treatments that were originally approved by the Plan and such request is not a Claim Involving Urgent Care, the Plan will treat your request as described in the section herein entitled "Claims For Benefits Requiring Precertification" or "Claims For Benefits Not Requiring Precertification," whichever is applicable to the request.

Precertification Denials and/or Claim Denials

If a request for precertification or a claim is denied or partly denied, you will receive a written or electronic notice of the denial, which will include:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provisions on which the denial is based;
- (c) if applicable, a description of any additional material or information necessary to complete the claim and the reason the Plan needs the material or information;
- (d) a description of the appeal procedures; the applicable time frames, including your right

to request an appeal within 180 days and your rights to bring a civil action following the appeal process; and

(e) any other information which may be required under state or federal laws and regulations.

Additionally, if the Plan made an Adverse Benefit Determination, you will receive a statement of your right to receive, upon request and free of charge, any internal rule, guideline, protocol or other similar criterion the Plan used in making an Adverse Benefit Determination.

Furthermore, if the Plan makes an Adverse Benefit Determination based upon their determination that:

- (a) the treatment and/or service is considered an Experimental or Investigational Drug or Treatment; or
- (b) the treatment and/or service is not Medically Necessary;

The Plan will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to you upon request, free of charge.

Appeals

If a request for precertification or a claim is denied or partly denied, you shall have a reasonable opportunity for an appeal and a right to a full and fair review. Please refer to the Appeal Rights provision.

“NOTICE - Trustee Discretion Retained. The Board of Trustees reserves the maximum legal discretionary authority to construe, interpret and apply the terms, rules and provisions of the Benefit Plan covered in this Descriptive Booklet. The Trustees retain full discretionary authority to make determinations on matters relating to eligibility for benefits, on matters relating to what services, supplies, care, drug therapy and treatments are Experimental, and on matters which pertain to Participant’s rights. The decisions of the claims adjusters, Administrator, and Board of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provision of the Benefit Plan, or application of such to any claim for benefits, shall receive the maximum deference provided by law and will be final and binding on all interested parties.”

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Employee Painters' Trust is required by law to maintain the privacy of your health information. We must provide you with this Notice of our legal duties and privacy practices with respect to your health information. We are also required to abide by the terms of this Notice, which may be amended from time to time.

We reserve the right to change the terms of this Notice at any time in the future and to make the new provisions effective for all health information that we maintain. We will promptly revise our Notice and distribute it to all plan participants whenever we make material changes to our privacy policies and procedures. Until then, we are required by law to comply with the current version of this Notice.

HOW THE EMPLOYEE PAINTERS' TRUST MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

We are permitted by law to use or disclose your "health information" to conduct activities necessary for "payment" and "health care operations" (as those terms are defined in the attached Glossary). There are other purposes for which we may use or disclose your health information, but these two are the main ones. For each of these primary purposes we list below examples of these kinds of uses and disclosures. These are only examples and are not intended to be a complete list of all the ways we may use or disclose your health information within each of these two categories.

Payment. We may use or disclose health information about you for purposes within the definition of "payment". These include, but are not limited to, the following purposes and examples:

- **Determining your eligibility for plan benefits.** For example, we may use information obtained from your employer to determine whether you have satisfied the Plan's requirements for active eligibility.
- **Obtaining contributions from you or your employer.** For example, we may send your employer a request for payment of contributions on your behalf, and we may send you information about premiums for COBRA continuation coverage.
- **Pre-certifying or pre-authorizing health care services.** For example, we may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.
- **Determining and fulfilling the Plan's responsibility for benefits.** For example, we may review health care claims to determine if specific services that were provided by your Physician are covered by the Plan.
- **Providing reimbursement for the treatment and services you received from health care providers.** For example, we may send your physician a payment with an explanation of how the amount of the payment was determined.
- **Subrogating health claim benefits for which a third party is liable.** For example, we may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.

- **Coordinating benefits with other plans under which you have health coverage.** For example, we may disclose information about your Plan benefits to another group health Plan in which you participate.
- **Obtaining payment under a contract of reinsurance.** For example, if the total amount of your claims exceeds a certain amount we may disclose information about your claims to our stop-loss insurance carrier.

Health Care Operations. We may use and disclose health information about you for purposes within the definition of “health care operations”. These purposes include, but are not limited to:

- **Conducting quality assessment and improvement activities.** For example, a supervisor or quality specialist may review health care claims to determine the accuracy of a processor’s work.
- **Case management and care coordination.** For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need.
- **Contacting you regarding treatment alternatives or other benefits and services that may be of interest to you.** For example, a case manager may contact you to give you information about alternative treatments which are neither included nor excluded in the Plan’s documentation of benefits but which may nevertheless be available in your situation.
- **Contacting health care providers with information about treatment alternatives.** For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting.
- **Employee training.** For example, training of new claims processors may include processing of claims for health benefits under close supervision.
- **Accreditation, certification, licensing, or credentialing activities.** For example, a company that provides professional services to the plan may disclose your health information to an auditor that is determining or verifying its compliances with standards for professional accreditation.
- **Securing or placing a contract for reinsurance of risk relating to claims for health care.** For example, your demographic information (such as age and sex) may be disclosed to carriers of stop loss insurance to obtain premium quotes.
- **Conducting or arranging for legal and auditing services.** For example, your health information may be disclosed to an auditor who is auditing the accuracy of claim adjudications.
- **Management activities relating to compliance with privacy regulations.** For example, the Privacy Officer may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy.
- **Resolution of internal grievances.** For example, your health information may be used in the process of settling a dispute about whether or not a violation of our privacy policies and procedures actually occurred.
- **Sale, transfer, merger, or consolidation.** For example, your health information may be disclosed if this health Plan merges with another health Plan.

- **De-identification of Health Information.** We may use or disclose your health information for the purpose of creating health information that is no longer identifiable as pertaining to you. Such de-identified health data may then be used for purposes that are not described in this notice as either permitted or required.
- **Creation of a Limited Data Set.** We may use your health information to create a “limited data set” which excludes most identifiers but may include partial addresses (city, state, and ZIP code), dates of birth and death, and other dates that pertain to your health care treatment. Such a “limited data set” may be disclosed for purposes of research, public health, or health care operations.

Disclosures to providers and to other health plans for their own activities related to your health care. We may disclose information to providers and to other health plans if it is intended to be used for their own purposes, as described below.

- **Treatment.** A health care provider may obtain your health information from us for the purpose of providing health care treatment. For example, we may disclose the identity of your primary care physician to emergency medical staff if requested for treatment purposes.
- **Payment.** A health care provider or another health plan may obtain your health information from us for purposes related to payment for health care. For example, if you have secondary coverage with another health plan we may disclose information to that other plan regarding our payments for your health care.
- **Health Care Operations.** A health care provider or another health plan may obtain your health information from us for some purposes related to health care operations, but only if the provider or plan has a relationship with you and the information pertains to that relationship. The purposes for which such disclosures are permitted include, but are not limited to, quality improvement, case management, performance evaluation, training and credentialing.

Other Uses and Disclosures. Other ways that the Employee Painters’ Trust may use and disclose your health information are described below. Not every potential use or disclosure in each category will be listed, and those that are listed may never actually occur.

- **Disclosures to You.** We are permitted, and in some circumstances required, to disclose your health information to you. Your rights are described below under “Your Health Information Privacy Rights”.
- **Your Personal Representative.** Anyone with legal standing to act as your personal representative may, depending on the terms of the legal authority, have any or all of the same rights that you have with regard to obtaining or controlling your health information. For example, state law determines the extent to which a parent may act on behalf of a minor with regard to the child’s health information. Someone who is legally responsible for your affairs after your death may also act as your Personal Representative.
- **Involvement in Payment.** With your agreement, we may disclose your health information to a relative, friend, or other person designated by you as being involved in payment for your health care. For example, if we are discussing your health benefits with you, and you wish to include your spouse or child in the conversation, we may disclose information to that person during the course of the conversation.

- **Required by Law.** We will disclose your health information when required to do so by federal, state, or local law. For example, we may disclose your information to a representative of the U.S. Department of Health and Human Services who is conducting a privacy regulation compliance review. We may also use and disclose your health information for purposes described below under “Your Health Information Privacy Rights”.
- **Public Health.** As permitted by law, we may disclose your health information as described below:
 - **To an authorized public health authority,** for purposes of preventing or controlling disease, injury or disability;
 - **To a government entity** authorized to receive reports of child abuse or neglect;
 - **To a person under the jurisdiction of the Food and Drug Administration,** for activities related to the quality, safety, or effectiveness of FDA-regulated products.
- **Health Oversight Activities.** We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system or of compliance with civil rights laws. However, this permission to disclose your health information does not apply to any investigation of you or which is directly related to your health care.
- **Judicial and Administrative Proceedings.** We may disclose your health information in the course of any administrative or judicial proceeding:
 - In response to an order of a court or administrative tribunal, or
 - In response to a subpoena, discovery request, or other lawful process.

Specific circumstances may require us to make reasonable efforts to notify you about the request or to obtain a court order protecting your health information.

- **Law Enforcement.** We may disclose your health information to a law enforcement official for various purposes, such as identifying or locating a suspect, fugitive, material witness or missing person.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.
- **Organ and Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Disclosures to Plan Sponsor. In addition to the circumstances and examples described above, there are three types of health information about you that we may disclose to Board of Trustees.

- We may disclose to Board of Trustees whether or not you have enrolled in, are participating in, or have disenrolled from this health plan.
- We may provide Board of Trustees with "summary health information", which includes claims totals without any personal identification except your ZIP code, for these two purposes:
 - To obtain health insurance premium bids from other health plans, or
 - To consider modifying, amending, or terminating the health plan.

- We may disclose your health information to Board of Trustees for purposes of administering benefits under the Plan. These purposes may include, but are not limited to:
 - Reviewing and making determinations regarding an appeal of a denial or reduction of benefits.
 - Evaluating situations involving suspected or actual fraudulent claims.
 - Monitoring benefit claims that may or do involve stop-loss insurance.

Business Associates. Business Associates are individuals and companies who need access to the personal health information for which we are responsible in order to act on our behalf or to provide us with services. Examples of business associates include third party administrators, pharmacy benefits managers, attorneys, consultants and auditors. We may disclose your health information to our business associates, and we may authorize them to use or disclose your health information for any or all of the same purposes for which we are permitted to use or disclose it ourselves, as well as for their own administrative purposes. Our business associates are contractually required not to use or disclose your health information for any other purposes.

WHEN THE EMPLOYEE PAINTERS' TRUST MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you have authorized us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization. However, we will be unable to take back any disclosures we have already made with your permission. Requests to revoke a prior authorization must be submitted in writing to the Privacy Contact Person.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

If you would like to obtain a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact:

Privacy Contact Person
Zenith Administrators, Inc.
201 Queen Anne Ave North
Seattle, WA 98102
1 (866) 277-3927

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Contact Person.

Right to Request Confidential Communications. You have the right to ask us to communicate with you using an alternative means or at an alternative location. Requests for confidential communications must be submitted in writing to the Privacy Contact Person. We are not required to agree to your request unless disclosure of your health information could endanger you.

Right to Inspect and Copy. You have the right to inspect and copy health information about you that may be used to make decisions about your Plan benefits. To inspect or copy such information,

you must submit your request in writing to the Privacy Contact Person. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

Right to Request Amendment. If you believe that we possess health information about you that is incorrect or incomplete, you have a right to ask us to amend it. To request an amendment of health records, you must make your request in writing to the Privacy Contact Person. Your request must include a reason for the request. We are not required to change your health information. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial.

Right to Accounting of Disclosures. You have the right to receive a list or “accounting” of disclosures of your health information made by us. However, we do not have to account for disclosures that were:

- made to you or were authorized by you, or
- for purposes of payment functions or health care operations.

Requests for an accounting of disclosures must be submitted in writing to the Privacy Contact Person. Your request should specify a time period within the last six years and may not include dates before April 14, 2003. We will provide one free list per twelve-month period, but we may charge you for additional lists.

Right to Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this Notice, contact the Privacy Contact Person.

Complaints. If you believe that your privacy rights have been violated by the Employee Painters’ Trust or by anyone acting on our behalf, you may send a written complaint to the Privacy Contact Person. You may also file a written complaint with the United States Department of Health and Human Services by writing to the Secretary at 200 Independence Avenue SW, Washington, DC 20201. Complaints about us must refer to the Employee Painters’ Trust by name and must describe what we did or failed to do that violated federal regulations regarding health information privacy. Complaints to the Secretary or to us must be filed within 180 days after you first knew or should have known about the privacy violation that is the subject of your complaint. We will not retaliate against you in any way for filing a complaint.

Questions. If you have questions about any part of this Notice or if you want more information about the privacy practices at the Employee Painters’ Trust, please contact the Privacy Contact Person at 1 (866) 227-3927.

SUMMARY PLAN DESCRIPTION
for
Employee Painters' Trust Health & Welfare
Plan

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The Employee Benefits Plan maintained by the Plan shall be referred to herein as the "Plan".

Name of Plan

This Plan is known as the Employee Painters' Trust Health & Welfare Plan. The Trust Fund through which this Plan is provided is known as the Employee Painters' Trust.

The Plan covers certain classes of employees who, in general, work for participating employers who are required to make contributions under various collective bargaining agreements to the Trust.

Board of Trustees - Plan Administrator

This Plan is sponsored and administered by a joint labor-management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees of The Employee Painters' Trust
c/o Zenith Administrators, Inc.
104 S. Freya, Suite 220
Spokane, Washington 99202
Phone: 1-509-534-0265 or 1-800-566-4455
Fax: 1-509-534-5910

Type of Administration

The Plan is administered by the Board of Trustees.

Name and Address of Agent for Service of Process

The Board of Trustees has designated:

Zenith Administrators, Inc.
104 S. Freya, Suite 220
Spokane, Washington 99202

as the agent for service of legal process. Service of legal process may also be made upon any Plan Trustee.

The Names and Addresses of the Trustees

Tim Bendokas
Bendokas Painting Co.
805 Rainier Avenue S
Seattle, WA 98144

Mike Ball
Painters District Council #5
2800 First Avenue, Room #324
Seattle, WA 98121

Nancy Gudmundson
Gudmundson Painting, Inc.
102 Lake Ave. S
Renton, WA 98057

Steve Bloom
Painters District Council #5
2800 First Avenue, Room #324
Seattle, WA 98121

Mike Guza
Rainbow Painting Co.
1705 6th Ave. N.
Great Falls, MT 59403

Tim Carrier
Painters District Council #5
11105 NE Sandy Blvd.
Portland, OR 97220

Gary Liles
Custom Painting, Inc.
North 3204 Cook
Spokane, WA 99207

John Smirk
Painters Local 159
1701 Whitney Mesa Drive, #105
Henderson, NV 89014

Bob Puzas
Rainbow Painting Co.
4126 S.E. Milwaukie
Portland, OR 97202

Identification Number

The identification number (EIN) assigned to the Plan Administrator by the Internal Revenue Service is 91-0597991, plan no. 501.

Plan Year

The plan year for this plan ends on June 30 of each year. The fiscal year for this Plan ends on July 31 of each year.

Each 12-month period ending on such date consists of an entire plan year for the purposes of accounting and all other reports to the U.S. Department of Labor and other appropriate regulatory bodies.

Type of Plan

This Plan can be described as a welfare plan which provides major medical, disability, accidental death and dismemberment, and Prescription Drug benefits.

Description of Collective Bargaining Agreement

This Plan is maintained pursuant to more than one collective bargaining agreement. A copy of such agreements may be obtained by participants and beneficiaries upon written request to the Trustees. Such agreements are also available for examination by participants and beneficiaries at the Trust Office, or at local Union offices upon 10 days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing copies. Participants and beneficiaries may wish to inquire as to the amount of charges before requesting copies.

Source of Contributions

These agreements generally provide that the employers who are parties thereto will make monthly contributions to the Employee Painters' Trust for the purpose of enabling the employees working under such agreements to participate in the Employee Painters' Trust Health & Welfare Plan. In addition, employee self-payments are also permitted for retiree coverage and to continue employee and dependent coverage.

Entities Used for Accumulation of Assets and Payment of Benefits

The employer contributions or employee self-payments are received and held in trust by the Board of Trustees pending the payment of claims and/or insurance premiums and administrative expenses. The balance is invested by the Board of Trustees and held as Trust reserves. Presently, the accidental death and dismemberment, weekly disability and major medical and retail prescription drug benefits are underwritten by United of Omaha, Mutual of Omaha Plaza, Omaha, Nebraska 68175. The dental and vision benefits are self-funded and paid directly from the Trust's assets.

Participation, Eligibility and Benefits

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements described in the above paragraph entitled "Description of Collective Bargaining Agreements," and if their employer makes contributions to the Trust on their behalf.

Circumstances Which May Result in Ineligibility or Denial of Benefits

An employee or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- (a) the employee's failure to work required hours to maintain eligibility; and
- (b) beneficiaries who are dependents of eligible employees may become ineligible if:
 - (1) the employee becomes ineligible;
 - (2) they are no longer dependents; or
 - (3) they have attained the disqualifying age.

An employee or beneficiary who is eligible may be denied benefits for one or more of the following reasons:

- (a) failure of the employee or beneficiary to file a claim for benefits within 15 months of the date they incurred the Expense for which benefits are payable; or
- (b) failure of the employee to file a complete and truthful benefit application.

NOTE: Any person who knowingly presents a false or fraudulent claim for payment, or prepares or makes any false or fraudulent account, certification, or other document or writing with

intent that it be presented or used in support of such claim, is guilty of a gross misdemeanor. Civil penalties, including interest, costs and attorney's fees will also be assessed on all false or fraudulent claims.

Where the employee or beneficiary has other group coverage, benefits under this Plan may be reduced or denied due to the Coordination of Benefits provision.

Filing of Claims

If you or one of your dependents become Disabled or incurs covered medical Expenses, you should immediately file the necessary claim form. Forms are available from the Trust Office, or your Local Union office. Charges for all services must be itemized.

PROPERLY COMPLETED CLAIM FORMS TOGETHER WITH ALL ITEMIZED BILLS AND OTHER REQUIRED PAPERS NECESSARY TO PROVE THE LOSS OR DISABILITY MUST BE RETURNED TO YOUR ADMINISTRATIVE OFFICE LOCATED AT P.O. BOX 2523, SPOKANE, WA 99220.

Procedures to be Followed in Presenting Claims for Benefits and Remedies Available for Mandatory Appeal of Claims Which are Denied

For details, refer to the following sections in this booklet.

For accidental death & dismemberment benefits refer to the Claim Review and Appeal Procedures. For weekly disability, refer to the Disability Claim Review Procedures and Appeal Rights. For medical, refer to the Appeal Rights and Precertification and Claim Review Procedures.

Procedures to be Followed in Presenting Claims for Benefits and Remedies Available for Voluntary Appeal of Claims Which Are Denied

To submit a claim for benefits under this Plan, it is necessary to complete and file a claim form with the Plan Administrator.

If your claim has been denied or partially denied, the Board of Trustees has adopted the following procedures to appeal benefit claim denials.

1. Plan Review

In the event a claim for benefits is denied or any employee or beneficiary feels he or she is adversely affected by the operation of the Plan, that person or his or her representative is entitled to a review of the decision. For specific information, refer to the Claim Review Procedure provision.

It is suggested that you contact Zenith Administrators, Inc. (the Plan administrative manager) before invoking the hearing procedures outlined below. They may be able to solve any problems and thereby save you considerable time and trouble.

2. Hearing Before Board of Trustees

Any participating employee or beneficiary of a participating employee who applies for benefits and is ruled ineligible by the trustees (or by a committee of trustees, an administrative agent, insurance carrier or other organization acting for the trustees) or who believes he or she did not receive the full amount of benefits to which he or she is entitled, or who is otherwise adversely affected by any action of the trustees, shall have the right to request the trustees to conduct a hearing in the matter, provided he or she makes such a request in writing within sixty

(60) days after being apprized of, or learning of, the action. The trustees shall then conduct a hearing at which the participating employee or beneficiary shall be entitled to present his or her position and any evidence in support thereof. The participating employee or beneficiary may be represented at any such hearing by an attorney or by any other representative of his or her choosing. Thereafter, the trustees shall issue a written decision affirming, modifying, or setting aside the former action.

The written decision of the trustees shall include the specific reasons for the decision as well as specific reference to the pertinent Plan provision(s) on which the decision is based and shall be written in a manner calculated to be understood by the claimant. If the claimant's position is denied, the written decision shall also include a notice of opportunity for legal action.

Certificate of Insurance

As an employee insured under the Plan, you will receive an individual certificate describing the benefits to which you are entitled under the group policies, and stating to whom such benefits are payable.

Change of Discontinuance of Plan

It is hoped this Plan will be continued indefinitely but, as with any group insurance Plan, the right of change or discontinuance by the trustees at any time must be reserved.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- (a) Receive Information About Your Plan and Benefits
 - (1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
 - (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
 - (3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- (b) Continue Group Medical, Dental and Vision Plan Coverage
 - (1) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may

have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- (2) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or us when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition waiting period after your enrollment date in your coverage.

(c) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “Fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

(d) Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(e) Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor,

200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

MEDICAL PLAN DISCLOSURES

You or your dependent are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, your booklet includes, as applicable, a description of:

- (a) Qualified Medical Support Orders;
- (b) any cost-sharing provisions, including premiums, deductibles, coinsurance and co-payments, maximums, details about the level of benefits, providers, preauthorization and utilization review rules, coverage for medical tests, devices and procedures, out-of-network coverage, limits on emergency care, coverage of existing and new drugs;
- (c) employee and dependent eligibility requirements;
- (d) any participating provider requirements; a current listing of such providers shall be furnished automatically as a separate document;
- (e) when insurance ends;
- (f) when benefits may be denied or reduced, including subrogation or reimbursement, and Coordination of Benefits provisions;
- (g) state or federal continuation rights;
- (h) claims procedures; additional details shall be furnished upon request; and
- (i) maternity hospitalization for the mother and newborn infant.

ACCIDENTAL DEATH & DISMEMBERMENT AND WEEKLY DISABILITY BENEFITS PLAN DISCLOSURES

You or your dependent are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, your booklet includes, as applicable, a description of:

- (a) employee and dependent eligibility requirements;
- (b) when insurance ends;
- (c) state or federal continuation rights; and
- (d) claims procedures; additional details shall be furnished upon request.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Plan are the Plan's Board of Trustees or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in your Booklet entitled "Changes in the Insurance Contract" for additional information about how the Plans can be changed. The Board of Trustees and the Plan Administrator are authorized to apply for and accept the Plan and any changes to the Plans.

MATERNITY BENEFITS

Under federal law, maternity benefits for inpatient confinement otherwise payable under the Plan shall not be restricted to less than 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section for the mother and the newborn. A provider is not required to obtain any prior authorization from the Plan for prescribing a length of stay not in excess of the above periods.